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ABSTRACT

This document contains program development information and a curriculum developed for a 2-year nursing program. The first five sections provide the following: development materials, samples of committee activities, program brochure, information sheet, course descriptions, and study guides and evaluation instruments for the nursing assistant and licensed practical nurse programs. The other 10 sections are syllabi for the following courses: nursing skills I and II, introduction to nursing, nutrition for nursing practice, pathophysiology I, pharmacology, intermediate nursing, intermediate nursing practice I, pathophysiology II, and intermediate nursing practice II. Each course syllabus consists of some or all of the following components: course title, course number, credits, lead instructor, resources, course description, methods of instruction, methods of evaluation, use of skills laboratory, grading, performance test information, and several units of instruction including information sheets, student performance records, and assignment sheets. (KC)

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ED330863

MEETING NEEDS IN NURSING--CURRICULUM DEVELOPMENT

PROJECT REPORT

Chippewa Valley Technical College

Eau Claire, WI

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CHIPPEWA VALLEY TECHNICAL COLLEGE
Project Report

01-075 Meeting Needs in Nursing - Curriculum Development

Data was gathered from advisory committee, practicing nurses and faculty committees for new content. This is a list of the materials that were developed following the committee process.

Brochure depicting the new curriculum, admission process, the career, and projected costs.

Courses:

Nursing Skills I: Individualized competency-based course in booklet form, purchased by students from bookstore.

Nursing Skills II: Individualized competency-based course in booklet form purchased by students from bookstore.

Introduction to Nursing: Introductory nursing concepts that include challenge options in theory and clinical competency in basic skills.

Introduction to Nursing Challenge: Study guides for Nursing Assistants and Licensed Practical Nurses who may challenge Nursing Skills I-II and Introduction to Nursing.

Intermediate Nursing: Theory course that includes laboratory component. New concepts are introduced.

Intermediate Nursing Practice: Clinical practice course including evaluation and checklist of competencies.

Nutrition for Nursing Practice: What nurses need to know.

Pharmacology: Essential information about drugs.

Pathophysiology I: Introductory concepts.

Pathophysiology II: Advanced concepts.

Advanced Nursing: This course and the remaining courses are still in process.

The nursing laboratory has been reorganized to accommodate competency-based learning. Sign-up sheets for checkoffs, charts, and schedules of faculty demonstrations are posted to facilitate information processing.

Because of the nature of the inservice/development process the initial 21 students were served during the second semester of 1988-89. A total of 72 students have benefitted from the implemented curriculum during 1989-90. It is anticipated that an additional 10-12 Licensed Practical Nurses will benefit from the project during the later portion of the second semester of 1989-90.

Nursing Project Report

01-076 Meeting High Employment Needs in Nursing - In-service

Chippewa Valley Technical College Nursing Faculty attended the following workshops in preparation for developing curriculum.

SUPPORTIVE MATERIALS

Library References on these topics assisted faculty with the development of curriculum and supportive learning activities.

Preparing Nurses for Using Information Systems
The Primary of Caring
Diagnostic Reasoning
The Art of Thinking
Guides to Credit By Examination
Critical Thinking
Instructional Designs and Alternatives to Education
Educational Outcomes: Assessment of Quality
Curriculum Revolution
Creative Thinking
Cultural Diversity

Audiovisuals were selected that are supportive of competency-based-instruction in the nursing laboratory. These audiovisuals supported achievement of skills in:

Personal Care
Hazards
Caring Concepts
Information Systems
Nursing Assessments
Geriatrics

FE/10-89/bh
FE/ProjRep.F89

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

LIST OF EXHIBITS

A. Development Materials, Samples of Committee Activities

B. Program Brochure, Information Sheet

C. Course Descriptions

D. Study Guide, Evaluation Instruments Nursing Assistant

E. Study Guide, Evaluation Instruments Licensed Practical Nurse

F. 510-101 Nursing Skills I

G. 510-114 Nursing Skills II

H. 510-110 Introduction to Nursing

I. 510-115 Nutrition for Nursing Practice

J. 510-122 Pathophysiology I

K. 510-130 Pharmacology

L. 510-160 Intermediate Nursing

M. 510-151 Intermediate Nursing Practice I

N. 510-123 Pathophysiology II

O. 510-153 Intermediate Nursing Practice II (Draft)

EXHIBIT A

To:
CVTC Area
Health Care
Agencies

In response to changing health care needs and technological advances, the CVTC Nursing faculty is revising the curriculum for the Associate Degree Nursing Program.

We would appreciate your completing the enclosed skills survey to assist us in updating the motor skills taught in our curriculum. Please distribute this survey to the nurses providing direct patient care in your facility. We request that you complete the survey by November 18, 1988, and return in the enclosed envelope.

Sonja Rathbun, R.N.
Instructor

Eleanor Walter, R.N.
Instructor

:bh

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Which of the following describes your health care facility?

____ Hospital
____ Extended care unit
____ Both

Skills Survey

Please indicate the frequency with which your staff performs the following skills. Your comments are appreciated.

	Freq.	Infreq.	Never	Comments
Handwashing				
Bedmaking				
Unoccupied bed				
Surgical bed				
Occupied bed				
Bathing				
Bed bath				
Partial bath				
Chair shower				
Sitz bath				
Back Massage				
Perineal Care				
Bed Shampoo				
Hair Care				
Nail Care				
Mouth Care				
Conscious patient				
Unconscious patient				
Dentures				
Feeding				
Intake-Output				

	Freq.	Infreq.	Never	Comments
Body Mechanics				
Assist to move in bed				
Positioning the patient				
Assist to ambulate				
Transfer to/from wheelchair				
Transfer to/from stretcher				
Use of Hoyer Lift				
Use of transfer belt				
Use of smooth mover				
Range of motion				
Active				
Passive				
Restraints				
Wrist				
Side rails				
Chest (posey)				
Vital Signs				
Temperature Oral Rectal Axillary Electronic				
Pulse and Respirations Apical pulse Pulse deficit Peripheral pulses				
Blood Pressure Lying Sitting Standing				
Weight Height Bed scale				
CMS checks (circulation, movement, sensation)				
Homan's sign				

	Freq.	Infreq.	Never	Comments
Toileting				
Urinal				
Bedpan				
Fracture pan				
Commode				
Collecting Specimens				
Stool				
Clean catch urine				
Sputum (include use of mucus trap)				
Wound drainage culture				
Enemas				
Soap suds				
Fleet				
Suppositories				
Removal of Fecal Impaction				
Douche				
Sterile Gloving				
Handling Sterile Supplies				
Isolation				
Catheterization				
Male				
Female				
Irrigation				
Sterile urine specimen				
Condom catheter				
Catheter Care				
Use of Leg Bag				
Clean Dressing Change				
Duoderm, opsite				
Sterile Dressing Change				
Surgical drains				
Wound Irrigation				
Warm Moist Packs				
K-Pad				
TEDS				

	Freq.	Infreq.	Never	Comments
Bandages				
Ace				
Sling				
Steri-strips				
Binders				
T				
Scultetus				
Velcro abdominal				
Changing IV Gown				
Medication Administration				
Oral				
Parenteral				
Intra dermal				
Sub q				
I.M.				
Z-track				
Eyedrops, eardrops				
Drug calculation				
Surgical gowning				
Surgical scrubbing				
Urostomy Appliances				
Colostomy Irrigation and Appliances				
Cough & Deep Breathing				
Leg Exercises				
Oxygen Therapy				
Aerosol Therapy				
Accucheck				
Venipuncture				
IV Therapy Including Blood				
IV Push Medications				
Central Line Care				
Trach Care				
Trach suctioning				
Heart Sounds				
Lung Sounds				

	Freq.	Infreq.	Never	Comments
Bowel Sounds				
Telemetry Transmitter Leads				
EKG Interpretation				
NG Tubes insertion & care				
Feeding tubes insertion & care Gastrostomy feedings Calculation of tube feeding mixtures				
Chest Tubes				
Neuro Checks				
Post Mortem Care				
CPR Certification				
Feeding infant through childhood				
Denver Developmental Screening Test				
Lazy Eye				
Care of patient in croupette				
Pediatric medication (math and injections				
Postural drainage				
Fetal Heart Tones/Doppler				
Reading Monitors (nonstress/stress)				
Leopold's Maneuvers				
Assist with circumcision				
Post partum check Breasts Fundus Lochia Episiotomy Homan's Sign				
Perineal care				
Cord care				

	Freq.	Infreq.	Never	Comments
Feedings				
Bottle				
Breast				
Newborns				
Temperature				
Apical pulse				
Respirations				
Height/weight				
Newborn assessment				
Labor				
Coaching breathing				
Timing contractions				

List any additional skills you anticipate future graduates need to know.

Additional comments:

SR/10-88/bh
CurRevis/Survey

CHIPPEWA VALLEY TECHNICAL COLLEGE

TECHNICAL NURSING CURRICULUM DEVELOPMENT
BLUEPRINT

Course Syllabus:

Course Number and Title

Credits:

Prerequisites:

Lead Instructor:

Resources:
   Textbooks
   References

Course Description:

Course Objectives:

Units of Instruction:

Methods of Instruction:

Methods of Evaluation:

Grading:

Policies and Procedures:

Outline

Unit Objectives	Content	Learning Activities

The philosophy reflects the faculty's belief about the person, society, environment, health, nursing, technical nursing practice, nursing education, and teaching/learning.

The conceptual framework defines the concepts and boundaries that serve as the basis for the nursing curriculum. Nursing theories and theories from other disciplines provide the foundation for nursing knowledge. The roles of nursing practice are reflected through the use of the nursing process. Gordon's Functional Health Patterns were selected by faculty to relate the components of the conceptual framework to clinical practice (Attachment A).

The attached framework adapted from NLN Committee on ADN Competencies Model (Attachment B) illustrates the relationship between education and nursing practice roles. The level objectives (Competencies, Attachment C) focus on the product of the total educational process and provide the framework for the curriculum.

FE/4-89/ADNBlueprint

FRAMEWORK
NURSING PRACTICE ROLES

		CARE GIVER	TEACHER	MANAGER OF CARE	INVESTIGATOR	MEMBER OF THE DISCIPLINE	
AREAS OF EDUCATION	KNOWLEDGE BASE						EDUCATIONAL OUTCOMES[1]
	PERFORMANCE COMPETENCIES						
	CRITICAL THINKING						
	HUMANISTIC VALUES (Humane Caring)						

LEVEL I COMPETENCIES

LEVEL II COMPETENCIES

LEVEL III COMPETENCIES[2]
(Graduation Competencies)

THE FUNCTIONAL HEALTH PATTERNS ATTACHMENT B

The Health Perception-Health Management Pattern refers to the patient's perceptions of his or her own health state and how his or her health goals and beliefs shape personal health care practices. The purpose of the assessment is to determine past and current health-seeking behaviors, compliance with both nursing and medical treatment recommendations, resources available for health maintenance, injury prevention practices, and whether and how the patient is seeking a higher level of well-being.

The Nutritional and Metabolic Pattern refers to the biopsychosocial states linked to food and water supply and the patient's functional or dysfunctional fluid and food patterns along with possible reasons, condition of the skin as a reflection of nutrition, and metabolic problems in temperature regulation. Weight, temperature, diet, fluid intake, and skin integrity are all assessed.

The Elimination Pattern describes a patient's urinary and bowel elimination patterns. The purpose of the assessment is to determine the adequacy of these patterns by assessing urinary and bowel routines, habits, and practices.

The Activity-Exercise Pattern refers to a patient's motivation and capability to engage in energy-consuming activities and conditions that affect these activities. The purpose of the assessment is to determine the patient's desire, choice, and actual involvement in leisure, work, self-care, and exercise. Also assessed are nursing diagnoses that can influence the activity pattern, such as tissue perfusion, cardiac output, breathing pattern, and gas exchange.

The Sleep-Rest Pattern refers to the patient's rest and sleep perceptions and practices. The purpose of the assessment is to determine the quality of the sleep and rest, as well as the patient's methods for promoting rest and sleep.

The Cognitive-Perceptual Pattern refers to the ability of the patient to perceive, understand, remember, and make decisions about information from the internal and external environment. The purpose of the assessment is to determine the status of the five senses and the use of any aids (for example, a hearing aid), degree of discomfort or pain, any perceptual alterations, and the patient's ability to understand, make decisions, and use good judgement. Also assessed is the patient's understanding of health care self-management practices and knowledge.

The Self-Perception-Self-Concept Pattern includes the patient's patterns of perception attitudes, and self-compentency. The purpose of the assessment is to determine the patient's attitudes and beliefs about personal abilities, identity, self-worth, and body image. Emotions and feelings such as grieving, anxiety, hopelessness, and powerlessness are also assessed.

The Role-Relationship Pattern involves the patient's needs and actual interactions with others at work, in the family, or in the community. The purpose of the assessment is to determine the patient's role and resonsibility at work, in the family, or in social life, including his or her communication skills and patterns. Areas in which the patient is adequate or experiences difficulty are both assessed. Also assessed are risk factors for self-harm and potential for inflicting physical harm on others.

The Sexuality-Reproductive Pattern refers to the patient's actual and perceived satisfaction or dysfunction in sexuality or reproduction. The purpose of assessment is to determine the patient's degree of satisfaction or dissatisfaction in fulfilling sexual and reproductive needs. Assessed are the patient's reproductive pattern and associated problems and concerns.

The Coping-Stress Tolerance Pattern refers to the patient's or family's adaptive or maladaptive response to stress and challenging life events. The purpose of the assessment is to determine the nature and degree of stressors stress response, and coping patterns. Assessed are perceptions of the stress and coping strategies and the resources available to the patient and family.

The Value-Belief Pattern includes the beliefs and values that guide a person's choices and life-style. The purpose of the assessment is to determine these life beliefs and values, including spirtual, religious, and philosophical beliefs.

LEVEL I COMPETENCIES

Provider of Care

Knowledge Base

Communication Skills
General Chemistry
Anatomy and Physiology
Psychology
Sociology
Developmental Psychology
Pharmacology
Nutrition
Pathology
Microbiology

Nursing principles, concepts and skills including the nursing process

Performance Competencies

Clinical Performance
Level Competencies
Graduate Competencies

Critical Thinking

Theory
Clinical Performance

Humanistic Values (Humane Caring)

Theory
Clinical Performance

TECHNICAL NURSING PROGRAM
CHIPPEWA VALLEY TECHNICAL COLLEGE
Eau Claire, Wisconsin

CONCEPTUAL FRAMEWORK

The conceptual framework of the technical nursing program depicts the concepts of Person, Health, and Nursing as gears that are dynamically joined through the process of adaptation. Adaptation occurs within the context of the environment of which society is an important part.

The concept of Person illustrates that each individual possesses spiritual, psychological, biological, cultural, and social facets. Boundaries between the facets, depicted as dotted lines, are theoretical and do not exist in reality.

Health is a dynamic state in which the person continues to develop adaptive capacity to his or her optimal level.

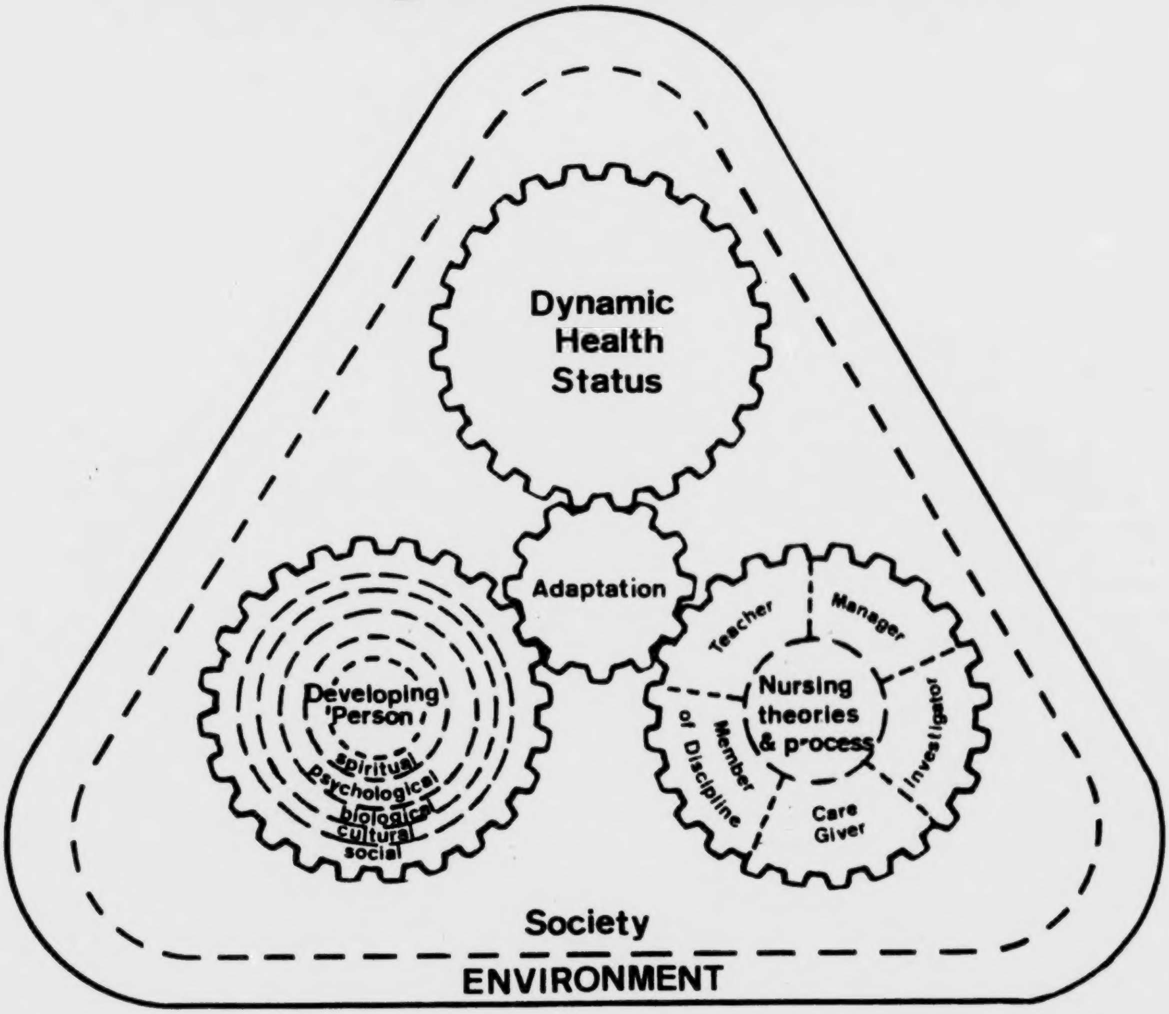
The Nursing component encompasses nursing theory, process, and roles as well as theories from other disciplines. The nurse interacts with consumers and providers of health care by assuming various roles while using the nursing process to facilitate the client's adaptation. Nurses seek to promote, maintain, and restore the health of individuals within the context of family and community. The Technical Nurse uses principles from a standardized body of knowledge in his/her role as a care-giver, teacher, manager of individual client care, participant in the investigation of nursing problems, and a member of the discipline.

Adaptation is the process which requires many regulatory and compensatory mechanisms to preserve equilibrium and facilitate continued growth. This process occurs within and between all components of the framework in constant interaction with the environment as depicted on the schematic drawing.

Society is the part of environment comprised of interdependent communities of persons, the basic unit being the family. Society influences health care, health policies, cultural norms, and legally and culturally expected parameters of nursing practice.

ConceptualFramework
Revised 1/88

Conceptual Framework



Dynamic Health Status
Adaptation
Developing Person
spiritual
psychological
biological
cultural
social
Nursing theories & process
Teacher
Manager
Investigator
Care Giver
Member of Discipline
Society
ENVIRONMENT

Technical Nursing Program
Eau Claire, Wisconsin
ADN Faculty, 10/87

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CHIPPEWA VALLEY TECHNICAL COLLEGE
Nursing Division
Admission Statement

Chippewa Valley Technical College and the nursing faculty are committed to providing the opportunity for area residents to pursue a career in nursing at the associate degree level. The enclosed informational packet will assist you to process your application to Chippewa Valley Technical College and the Technical Nursing Program. You will need to make an appointment with the nursing supervisor, Florence Erickson, by calling 833-6417 for academic advising, selection, sequencing, and scheduling of courses.

Introduction to Technical Nursing

The technical nursing program is a two year associate degree registered nursing program. Candidates who have met the prerequisite high school algebra, chemistry, and biology (C or above) requirements to the science and nursing courses, and score in the 45th percentile or above in the pre-nursing examination are eligible to register for the next level courses. Post high school proficiency in general chemistry is a prerequisite to Biochemistry. Proficiency in general chemistry can be demonstrated by passing the general chemistry proficiency examination or a grade of C or above in 806-121 General Chemistry at Chippewa Valley Technical College. This requirement can also be met by completing a college credit general chemistry course with a grade of C or above. Students entering the nursing core courses in August will need to complete the post high school chemistry proficiency during the summer prior to entry. Students entering the nursing core courses in January may complete the proficiency the summer following entry.

The career guidance center is available for candidates who wish to examine their career choice and/or have deficiencies in the above courses. Candidates are encouraged to pursue self learning activities to prepare for program entry. The Phillips Autotutorial Center located in the lower level of the Phillips Building (across the street from the main building) is available to candidates preparing for program entry. A list of recommended learning aids will be posted in the autotutorial laboratory.

Coursework can be completed in four (4) semesters and one (1) summer session. The faculty recognize that each student has unique abilities and personal responsibilities that may require part-time programming. Those students are advised to enroll in some general education courses prior to beginning the 510 nursing courses. This would decrease the number of credits each semester and allow the students to concentrate on science and nursing courses. Candidates for the nursing program are expected to attend a general orientation session conducted by student services personnel during the week of orientation. The time will be identified in your registration packet. The nursing supervisor will meet with you following the general orientation session to clarify the admission process, answer questions and discuss the field of nursing. Each technical nursing candidate must also attend a nursing program orientation session prior to entering the 510 nursing courses.

Candidates will be provided with the date of the specific nursing orientation prior to beginning the nursing courses. This orientation will address: class/laboratory/clinical schedules, liability insurance fees, uniforms, policies, teaching methodology, program philosophy, conceptual framework, and physical examination requirements.

Admission to the Program

All students who meet the stated requirements have an equal opportunity to be admitted to the nursing program. In situations where there are more students than program slots, students will be placed on a waiting list.

Initial application is made through the admissions coordinator in Student Services. A file for each student is created in the admission office following application to the technical nursing program. The student is then referred to the supervisor of nursing or her designee for academic advising, sequencing coursework and challenge of courses in order to process program entry. A separate file is initiated in the nursing division for each nursing student following the initial academic counseling session.

Process and Procedure

1. Make application to the program through the admissions office.
2. Read the materials in the information packet provided by admissions.
3. Identify yourself to the nursing division supervisor to plan your program of study.
4. Follow directions on the checklist and notify admissions of progress toward meeting admission requirements.
5. Transcripts reflecting credits for advanced standing must be submitted to and processed by the registrar. Concerns and questions regarding appropriate credit will be dealt with by the registrar and nursing supervisor. Following transfer of credit the transcript is placed in the student file in student services.
6. Following payment of fees a students record is entered in the computer terminal through the admissions office. The student file is retained in the registrar's office.

Following entrance to the nursing courses, the student is assigned a faculty advisor. An informational pamphlet with program policies and costs is provided for each student at orientation.

The employment picture for graduates of the program is excellent with placement in local, regional and nationally located health care agencies. The future nurse can expect expanded job opportunities in freestanding specialized health care centers, extended health care facilities, rehabilitation centers, patients homes, community clinics, maternity centers, adult day-care centers, medical supply companies, insurance firms, and the armed services.

Technical nursing is a two track program designed to admit students with no previous nursing experience (generic) or licensed practical nurses with experience in nursing (completion). Assessment of prior learning and advanced standing is available to all students who have credit from other institutions, colleges and universities.

9/87/mo
AdmissionStatement

ASSUMPTIONS ABOUT CURRICULUM

Curriculum Threads

Nursing Process
- Assessment
- Planning
- Interventions
- Evaluation

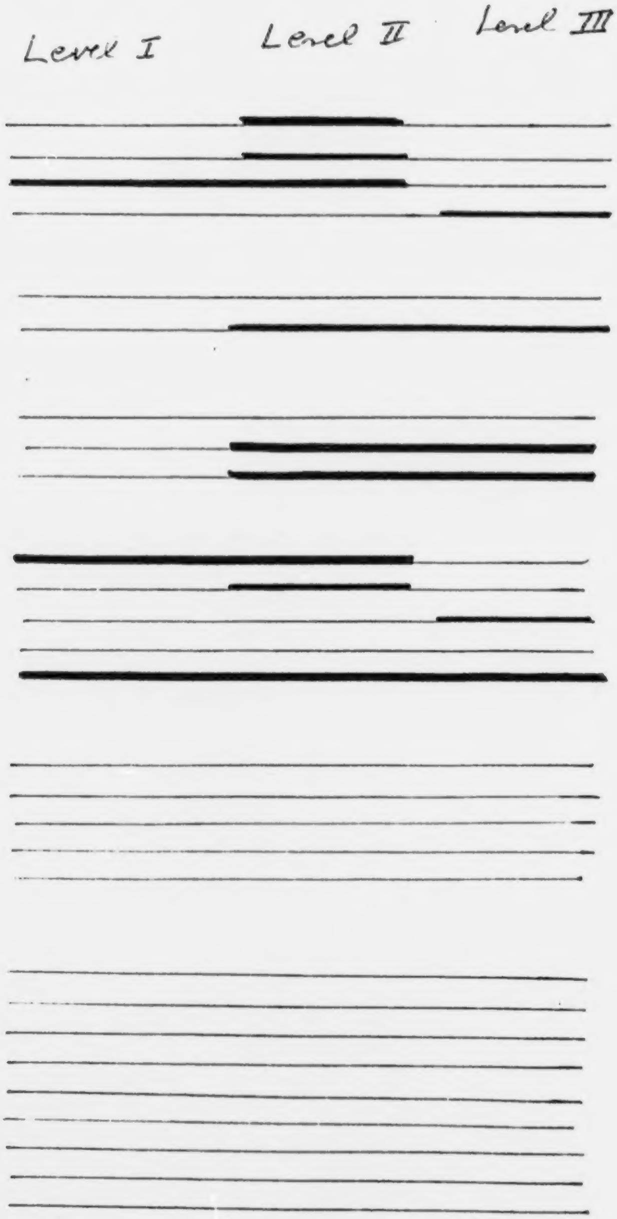
Caring
- Empathy
- Therapeutic use of self

Rational Thinking
- Dispositions
- Critical Thinking
- Creative Thinking

Nursing Roles
- Care-giver
- Teacher
- Manager
- Investigator
- Member of discipline

Human Development
- Biological
- Psychological
- Cultural
- Social
- Spiritual

Health Status
- Nutrition
- Elimination
- Regulation
- Rest/comfort
- Mobility
- Oxygenation
- Love and belonging
- Safety and security
- Self-esteem



Levels

Level I	equivalent to nursing assistant
Level II	equivalent to LPN
Level III	equivalent to RN

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

PROPOSED PSYCHOGERIATRIC CONTENT AND SEQUENCE

PSYCHOGERIATRIC CURRICULUM COMMITTEE

Janet O'Brien
Kay Froehner
Roxie Zielie Sherer

Developmental Psych Course

Identify normal aging process:

- Biology of aging
- Developmental tasks
- Ego-integrity and positive self-concept
- Cross cultural perspectives on aging
- Sociology of aging

The committee recommends that this content be included in the first nine weeks of the Introduction to Nursing course to facilitate the total geriatric assessment required in the nursing home experience.

Nutrition Course

will include geriatric nutrition.

Pharmacology Course

will include content on pharmacology and the elderly.

I	II	III
Intro to Nursing	Intermediate Nursing I Theory	
Reality orientation	Stressors that place the aging population at risk. Nursing process and the aged; identify age related changes in data collection. Grief and loss issues and the elderly. Reality orientation in the acute setting; surgical client.	
Clinical	Clinical	
Reality orientation in the elderly client.	Support services that are age specific.	
	Advanced Nursing I Theory	
	Mental Health and Aging: identify mental health vs. mental illness in the aged population, with articulation of the nursing process to these health states. Content to be covered under this mental health focus would be: 1) depression vs dimentia 2) anxiety states 3) sexuality/intimacy 4) sensory stimulation/ interventions: reminiscent therapy, group interventions 5) motivation 6) Alzheimer's Disease 7) Mental Status Exam 8) delirium vs dimentia	
	Clinical	
	Mental Health Settings	

III

Advanced Nursing II

High Risk Elderly: identify the high risk elderly client with articulation of the nursing process to these health states.

1) mental illness combined with chronic illness
2) developmentally disabled elderly
3) victimization of the elderly, abuse issues
4) elder care issues, family role changes and stressors
5) medical ethics
6) long-term care of the elderly

Clinical

Overall Recommendations: To provide the student with experience working with both independent and dependent elderly.

1) independent living assessments
2) clinical experience in a nursing home
3) hospital based experience with the ill elderly
4) community based programs and services

JO/4-89/bh
PsychogeriContent

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

TO: Florence Erickson

FROM: Curriculum Committee on Chemical, Physical, and Biological Hazards: R. Anderson, D. Peterson, C. Solsrud
RA

DATE: October 10, 1988

Attached is a listing of hazards-related content identified as being appropriate for inclusion in the new curriculum. Content was arbitrarily numbered for identification and then grouped and sequenced as follows:

First: Information from basic sciences - 1, 21

Second: Information essential to safe implementation of introductory level nursing skills - 7, 16, 13, 19, 17, 22, 26, 25, 24, 27, 28, 3a, 3c, 4, 5.

Third: Information regarding the mechanisms of action of hazards within the human being - 23, 2, 3d, 3e, 6, 10, 14, 20, 15.

Fourth: Information regarding specific complex hazard states or situations - 3b, 9, 11, 12, 18, 8.

In reviewing the course objectives (1/88) for the new curriculum, objective 1.8, caregiver, level I, suggests placement of hazards content early, however, because some of the content builds on other content it will be necessary to spread the content throughout the curriculum. Some items, e. g. 13, 19, should be introduced early at a knowledge level but should also be dealt with later at a more analytical or evaluative level.

For ease of reading, the content items are typed below in original organization as well as in the recommended sequence.

Original Organization:

Hazards to Client   Aspects Relevant to Nurse

CHEMICAL:

1. behavior of atoms/molecules)
   structure & interactions of) (Chemistry)
   chemicals in biologic systems)

2. endogenous chemicals:
   nitrogen wastes
   bilirubin
   CO_2/O_2

3. exogenous chemicals:
   a) interactions in body:
      exposure
      absorption
      distribution
      action
      breakdown
      elimination

b) poisoning - emergency care and prevention	
c) drugs/alcohol side effects toxic effects habituation/abuse safeguards in administration	4. drug hazards and abuse in health care professionals 5. laws regarding controlled substances
d) nutrients excess deficits	
e) environmental pollutants including carcinogens & antigens food additives and contaminants other - eg: air, water, asbestos, coal dust, silica, pollen, cosmetics	6. anesthetic gases disinfectants

PHYSICAL:

7. falls prevention by means of proper moving, lifting, ambulating, etc.	16. body mechanics back injuries
8. multiple trauma - e.g. automobile accidents	17. documentation on incident reports, procedure permits, etc.
9. domestic abuse	
10. immobility	
11. violent patients	18. violent patients
12. suicidal behavior	
13. client abuse by health care giver	19. client rights, e.g.: feeding medications answering lights smoking procedure consents
14. radiation therapeutic accidental large dose exposure sunlight, radon	20. radiation exposure, e.g. X-rays care of patients in nuclear medicine lasers
15. heat and cold burns, frostbite hypo and hyperthermia	

BIOLOGICAL:

21. characteristics and behaviors of microbes >(Microbiology)

22. principles of microbial transmission

23. infection in the host
    a) acute/chronic infection process
    b) resistance to infection, immune system and immunization

24. isolation technique

25. sterile technique

26. aseptic technique

27. exposure to microbes, protective devices and behavior

28. ethical aspects of self and patient protection

Recommended Sequence:

1. behavior of atoms/molecules)
structure and interactions of)
chemicals in biologic systems) (Chemistry)

Psychosocial Hazards
stress - early
shiftwork - later
management

21. characteristics and behaviors of microbes - (Microbiology)

7. falls
prevention by means of proper moving, lifting, ambulating, etc.

16. body mechanics
> (nurse focus)
back injuries

13. client abuse by health caregiver

19. client rights, e.g.:)
feeding)
medications) (nurse focus)
answering lights)
smoking)
procedure consents)

17. documentation on incident reports, procedure permits, etc.

22. principles of microbial transmission

26. aseptic technique

25. sterile technique

24. isolation technique

27. exposure to microbes, protective devices and behaviors (nurse focus)

28. ethical aspects of self and patient protection (nurse focus)

3a. interactions in body
    exposure
    absorption
    distribution
    action
    breakdown
    elimination

3c. drugs/alcohol
    side effects
    toxic effects
    habituation/abuse
    safeguards in administration

4. drug hazards and abuse in health care professionals (nurse focus)

5. laws regarding controlled substances (nurse focus)

23. infection in the host
    a) acute/chronic infection process
    b) resistance to infection, immune system and immunization

2. endogenous chemicals
    nitrogen wastes
    bilirubin
    CO_2/O_2

3d. nutrients
    excess
    deficits

3e. environmental pollutants including carcinogens and antigens
    a) food additives and contaminants
    b) other, e.g. air, water, asbestos, coal dust, silica, pollen, cosmetics

6. anesthetic gases
    > (nurse focus)
disinfectants

10. immobility

14. radiation
    therapeutic
    accidental large dose exposure
    sunlight
    radon

20. radiation exposure, e.g. X-rays,)
    care of patients in nuclear medicine)(nurse focus)
lasers)

15. heat and cold
    - burns
    - frostbite
    - hypo and hyperthermia

3b. poisoning - emergency care and prevention

9. domestic abuse

11. violent patients

12. suicidal behavior

18. violent patients (nurse focus)

8. multiple trauma, e.g. automobile accidents

:bh

c: D. Peterson
C. Solsrud

Geri-Psych Curriculum Objectives

The rationale for including Geri-Psychiatric concepts in the framework of the nursing curriculum reflects the assumption that the practice of nursing needs to address the needs of the rapid and continuing growth of the aging population.

Recommendations:

The nursing curriculum content can subdivided among these core content areas: 1)Psychological Aspects of Aging, 2) Social Aspects of Aging, 3) Health and Aging, 4) Aging Programs and Services.

Proposed Sequencing

Level I Psychological aspects and social aspects of aging-Geriatric Focus.

1) Identify the normal aging process vs the chronic disease state
Content to be covered under this normal aging focus would be:
1)Biology of aging, 2) developmental tasks and stages of aging, 3)ego-integrity and positive self concept, 4) cross-cultural perspectives on aging 5) stressors that place the aging population at risk, 6)historical events that have affected the aging population, 7) geriatric nutrition, 8)pharmacology and the elderly, 9)
10) 11)

Three main threads that would be presented here in Level I that would continue through out the curriculum would be
1)Support Services that are age specific
2) Nursing Process and the Aged
3) Grief and Loss Issues and the Elderly

Level II Mental Health and Aging

1) 'Identify mental health vs mental illness in the aged population, with articulation of the nursing process to these health states.
Content to be covered under this mental health focus would be:
1) depression vs dimentia, 2) anxiety states, 3) sexuality/Intimacy 4)sensory stimulation/interventions, 5) motivation, 6) daycare concepts 7) Alzhiemer's Disease, 8)Mental Status Exam, 9) delirium vs dimentia

Level III High Risk Elderly

1) Identify the high risk elderly client with articulation of the nursing process to these health states.
Content to be covered under this high risk focus would be:
1) Mental illness combined with chronic illness 2)Developmentally disabled elderly, 3) victimization of the elderly, abuse issues, 4) Elder care issues, family role changes and stressors, 5) medical ethics, 6) long-term care of the elderly

Clinical Recommendations

To provide the student with experience working with both independent and dependent elderly.

1) Independent Living Assessments
2) Clinical Experience in a nursing home
3) Hospital bases experience with the ill elderly
4) Community based programs and services

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

NURSING ASSISTANT COMPETENCIES

Communication:

1. identify components of provider-client relationship
2. ways to cope with stress
3. use of body language (nonverbal communication)
4. recognize uniqueness of individual, cultural, generational, social, ethnic, religious
5. recognize what constitutes abuse
6. communicate with respect and dignity for client
7. explain procedures
8. demonstrate acceptance and concern for dying and those with long term illness
9. use appropriate verbal communication
10. effective listener - aware of listening techniques
11. identify assertive vs. aggressive responses
12. distinguish between acceptable and unacceptable touching
13. know specialized techniques with clients that wanders and are confused
14. recognize common barriers to communication, language, vision changes, hearing loss, speech problems, memory loss and disorientation
15. identify role of family and other support persons to the client's care as a resource for clients emotional support
16. identify how and when to seek guidance, using the supervisory channels of communication within the agency
17. recognize the components of working relationships
18. recognize the role of client advocacy groups as client resource

Reporting and Recording:

1. observe and report changes in client behavior and physical status
2. recognize and report deviations from client's normal food and fluid I/O
3. record objective information such as client's height and weight

4. report every instance of abuse, mistreatment or neglect on a client to appropriate facility staff
5. demonstrate awareness of how to file a complaint with the department regarding operations within the provider setting
6. channels of communication
7. demonstrate introductory levels of knowledge of common medical terms and abbreviations

Mobility:

1. use proper body mechanics
2. demonstrate an ability to promote the independence of clients within the limitations of their physical, mental and intellectual impairments
3. demonstrate appropriate techniques in walking, transferring, positioning and transporting clients
4. maintain and improve musculoskeletal functioning by promoting joint mobility, body alignment and movement
5. be able to position clients using supportive devices, including pillows, towel rolls, padding and footboards
6. perform ROM
7. assist clients to use crutches, walkers, wheelchairs, canes, prostheses and appliances
8. transfer clients as necessary using Hoyer lift, wheelchair and gait belts
9. reinforce breathing exercises, including coughing and deep breathing

Legal Issues (Client's Rights):

1. provide privacy for clients in treatment and living arrangements and caring for personal needs
2. maintain confidentiality of client health and personal record
3. allow clients to make personal choices to accommodate their needs
4. provide needed help to clients in getting to and participating in activities, including client and family group meetings
5. maintain personal possessions of clients in good condition
6. caring for clients in a manner that does not involve abuse, mistreatment or neglect

7. report every instance of abuse, mistreatment or neglect of a client to appropriate facility staff

8. recognize what constitutes neglect, physical abuse and verbal abuse and how to avoid behavior that can be interpreted as neglect or abuse

9. demonstrate concern for each client's rights and preferences in regard to culture, ethnic, religious and food preferences

10. demonstrate prevention and intervention skills with combative clients to protect client, self and others

11. recognize the role of state and federal regulatory agencies in licensing providers and investigating complaints of neglect, abuse

12. demonstrate understanding of the process by which a client or staff member may file a grievance on behalf of a client and seek redress for a perceived violation of client rights

13. demonstrate awareness of how to file a complaint with the department regarding operations within the provider setting

Asepsis Medical:

1. demonstrate appropriate handwashing techniques

2. make use of proper isolation techniques

3. perform commonly accepted infection control practices including proper gloving techniques and proper disposal of blood and body fluids and secretions

4. apply over-the-counter topical applications to unbroken skin areas

Protection:

1. recognize the circumstances that require assistance to a client who may be choking on ingested food particles

2. recognize and respond appropriately to unsafe environmental conditions, damp floors, frayed electrical cords and loose hand bars and rails

3. recognize and respond appropriately to emergency situations including following emergency evacuation procedures

4. apply soft restraints

5. maintain the safety and cleanliness of client areas and areas where food is stored

Personal Care:

1. help clients use hearing aids and glasses
2. recognize importance of bowel and bladder programs and assist with bowel and bladder elimination
3. foster self-help skills through appropriate responses to clients attempts to provide self care
4. recognize client's level of ability in self care activities
5. demonstrate acceptable personal hygiene habits
6. recognize normal physical and psychological changes associated with aging
7. identify basic principles of nutrition and hydration
8. recognize basic requirements of commonly prescribed therapeutic diets

Personal Care:

1. measure clients height, weight and record
2. measure clients temperature, pulse, respirations and blood pressure
3. give complete or partial bed bath and assist clients in taking baths and showers
4. provide care of perineal area
5. provide oral hygiene, including dentures
6. provide nail, hair, skin and back care
7. shave and shampoo clients, including over-the-counter medicated shampoo
8. dress and undress clients
9. prepare clients for meals
10. assist feeding clients including shaving use of adaptive feeding devices
11. make occupied and unoccupied beds
12. assist with post mortem care

Demenitas:

1. nature - cause, course and symptoms and impairments
2. approaches to facilitate effective interaction between clients and staff
3. specialized techniques for addressing problems of feeding and fluid intake problems
4. use of appropriate environmental stimuli with clients to reduce stress and maximize normal functioning
5. specialized therapeutic interventions for responding to client behavior such as wandering and confusion
6. use of diversional activities etc., soft music, TV programs and therapeutic ambulation
7. techniques for coping with stress that involves client, family and nurses assistant

EW/4-89/bh
NACompetencies

CHIPPEWA VALLEY TECHNICAL COLLEGE

NURSING DIVISION

Critical and creative thinking concepts will be introduced in the first nursing course of the new curriculum. This new nursing curriculum is scheduled for implementation in August, 1989. Critical and creative thinking skills will then be infused throughout. Initially the faculty intends the nursing curriculum to focus on critical thinking in terms of "self", then progress to critical thinking in terms of "others", to the integration of more sophisticated thinking and reasoning abilities.

Coaching Activities by Instructor

1. Assist the students to progress from the application of concepts to their own experiences to more abstract application of concepts to the experiences of others.
2. Engage the student in exercises and activities that stimulate the acceptance of the role of active participation in selecting and rejecting information and rejection of the role of passive absorber of information.
3. Engage the student in exercises that promote the ability to recognize organization, issues and conclusions of expository texts.

The student will:

1. develop confidence in his/her ability to make rational choices about issues.
2. develop question-asking skills that can be applied to a variety of situations.
3. acquaint self with strategies of rational thinking by recognizing characteristics of fair-mindedness.
4. demonstrate willingness to explore novel solutions to problems.
5. actively seek imaginative solutions to problems.
6. exhibit intellectual curiosity.

PROPOSED CONTENT

I. Rational thinking dispositions
    A. Fair-mindedness
        1. Attitudes, beliefs, values
        2. Egocentricity
        3. Sociocentricity
        4. Reciprocity
        5. Passion for truth
    B. Intellectual curiosity
        1. Confidence in own abilities to reason
        2. Willingness to make mistakes
        3. Willingness to subject ideas to scrutiny
        4. Healthy attitude toward argumentation
        5. Interest in widening experience
        6. Searching for challenges

II. Analysis of issues
    A. Defining issues accurately
    B. Interpreting factual data accurately
    C. Recognizing and evaluating unstated assumptions
    D. Evaluating credibility of sources
    E. Detecting fallacies
    F. Formulating judgments based on evidence

III. Problem-solving
    A. Novelty
    B. Fluency
    C. Flexibility
    D. Testing hypothesis

IV. Decision-making
    A. Nursing Code of Ethics
    B. Ethical Principles
    C. Implications of decision

FE/6-89/bh
CritCreatThink

CRITICAL THINKING: CONTENT

I. Rational thinking dispositions
    A. Fairmindedness
        1. Attitudes, beliefs, values
        2. Egocentricity
        3. Sociocentricity
        4. Reciprocity
        5. Passion for truth
    B. Intellectual curiosity
        1. Confidence in own abilities to reason
        2. Willingness to make mistakes
        3. Willingness to subject ideas to scrutiny
        4. Healthy attitude toward argumentation
        5. Interest in widening experience
        6. Searching for challenges

II. Analysis of issues
    A. Defining issues accurately
    B. Interpreting factual data accurately
    C. Recognizing and evaluating unstated assumptions
    D. Evaluating credibility of sources
    E. Detecting fallacies
    F. Formulating judgments based on evidence

III. Problem-solving
    A. Novelty
    B. Fluency
    C. Flexibility
    D. Testing hypothesis

IV. Decision-making
    A. Ethical Principles
    B. Implications of decision

REMODELING OF A LESSON PLAN

A. Grade: First Year Nursing Students

B. Title of Lesson: Problem Solving - Altered Nutrition Related To Depression

C. OBJECTIVES:

1. Use questioning skills to identify the problem
2. Use deductive reasoning to clarify the problem
3. Make inferences from baseline data
4. Use resources to identify alterations
5. Discuss the advantages and disadvantages of alteration
6. Generate a solution to the problem
7. Contrast the positive potential outcomes with the negative potential outcomes

D. ORIGINAL LESSON PLAN:

1. Abstract

Students read a description of a nursing situation in which a patient is admitted to the hospital with a recent history of depression. They learn that the patient, Ida Miller, worked as a secretary at a local construction company. She is the mother of two teenage daughters. Her husband, a truck driver, has not visited her since she was admitted to the hospital. She has eaten very little since her admission. Her physician stated that she will start intravenous feedings if Ms Miller does not begin to eat. The student is assigned to develop a care plan that is designed to identify the process leading to the resolution of the eating problem.

Some of the questions the students are expected to address are factual in nature, however, many foster independent thinking revolving around the use of the nursing process (assessment, nursing diagnosis, planning, implementation and evaluation) by gathering data, identifying client goals designing and implementing strategies to achieve the goals, and determining the extent to which the goals have been achieved. Many of the questions require students to assess the situation and validate information and the effectiveness of the action taken.

CRITIQUE:

The original lesson plan requires students to clarify some information, e. g., " How long since Ida worked ?" pursue some questioning, e. g., " Has her husband called ? " " How long has she been hospitalized ? " The text addresses methods for using the nursing process and foster independent thinking, however, the text fails to consistently draw upon the appropriate abstract and logical form of thought that lead to justification of nursing action. The use of the evaluation process does not consider alternatives to the plan until a plan has not been effective. By using alternatives and seeking other viewpoints, especially that of the patient, the student would avoid making the assumption that the patient is not capable of negotiating action. By including the patient in the identification of possible courses of action, the nursing student can explore other views with not only the patient but with members of the health care team.

E. STRATEGIES USED TO REMODEL:

The title of the lesson plan could be changed to:

" Therapeutic Use of Self In The Form of A Caring Presence When Solving Problems".

1. Clarifying ideas
2. Avoiding oversimplification
3. Evaluating source credibility
4. Making interdisciplinary connections
5. Developing insight into ego/sociocentricity
6 Exploring implications and consequences
7. Integrating critical vocabulary

F. REMODELED LESSON PLAN:

The use of the nursing care plan format in the education of nursing students has promoted the tendency to think in narrow self-serving ways, e. g., "look for ready-made solutions in packaged care plans". The teacher should encourage students to think critically and reflectively about the patient's situation, the viewpoint of members of the family, the viewpoint of the patient, and the rationale for the medical regime recommended by the physician, and develop the care plan based on this information. [S-2] Although the original lesson asks clarification questions, the teachers could expand [S-10] on these questions by asking the students to list advantages and disadvantages when responding to the question " Is it healthy for Ida to make plans to return to work"? " Is it appropriate to pursue this in the plan at this time"? The teacher - student transactions should be designed to avoid oversimplification in relation to the Ida's health status and her occupation [S-6]. Students may need to return to the data base to find more information. Teachers need to direct students to seek additional information by asking questions such as; " Was Ida depressed when she was working"? " Did she become depressed after she stopped working"? " "How does Ida feel about her weight"? " What are the advantages of being overweight, disadvantages"? "Did the weight affect her ability to hold her position"? [S-25] The original lesson plan directed the students to use concrete evidence in their data base, however, clear directions needed to be conveyed to students to make interdisciplinary connections [S-18] in the behaviors that were identified. The teacher needs to nurture the spirit of inquiry and curiosity, together with the desire to seek collaborative communication with interdisciplinary team in order to evaluate the credibility of their sources [S-12]. There are several opportunities in the patient situation where the teacher could encourage students to explore implications; [S-30] "Did the husband not visit because he was on a scheduled extended transport"? and consequences, " What were Ida's options in terms of loneliness"? "In terms of care, love and supervision of the teenage children"? "Was there a emotional support system for the family"? " Is Ida not eating because of the weight"? [S-6] The directions in the original lesson plan addressed the weight problem in terms of the medical regimen but did not further probe the students' perception of how weight can be "good" or " bad". Nursing educators who teach the problem-solving approach to nursing situations have many opportunities to provide students with situations in which to practice critical thinking vocabulary [S-23]. The directions in the original lesson plan cautioned the student not to diagnose patterns with isolated data [S-6] because inference [S-23] drawn from the data could be misleading. Examples of how teachers should expand on critical thinking vocabulary are: "What assumption is made by the writer's description of "very little" food? [S-25] "Does this description of a data base meet the objectives of the lesson"? "How much time before the physician initiates the intravenous feedings"? "Is this what Ida wants"? [S-10] "What can the student infer from the information given"? "How can you tell"? "What can be assumed in the description"? "What can not be assumed"? "How do you know"?

Caring : Content

I. Overview of terminology and basic features of caring theories as they relate to nursing (Watson, Benner & Wrubel, Leininger, Gaut) including but not limited to:

- API A. views of person, particularly phenomenological vs. mechanistic
- Intro B. health-illness
- Intro C. stress-coping
- Intro Intermed. D. nursing as human science and art with caring as its core
- API E. connectedness (mutuality, concern)

II. Exploration of caring behaviors as applied to clinical nursing.

- Intermed. A. Carative factors as applied in areas of developing helping-trust relationships, teaching-learning, environment management, and needs gratification (Watson).
    1. formation of humanistic-altruistic value system
    2. Instillation of faith and hope
    3. cultivation of sensitivity to self and others
    4. development of helping-trust relationship
    5. promotion and acceptance of positive and negative expression of feeling
    6. utilization of scientific problem solving methods for decision-making

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Intermed
7. promotion of interpersonal teaching and learning
8. provision for supportive, protective and/or corrective mental, physical, sociocultural, and spiritual environment API

Intermed. 9. assistance with human need gratification

API 10. allowance for existential-phenomenological forces

Info B. Caring behavior inventory (Wolf)

1. attentive listening
2. comforting
3. honesty
4. patience
5. responsibility
6. providing information so that the patient or client can make informed decisions
7. touch
8. sensitivity
9. respect
10. calling the patient or client by name

BIBLIOGRAPHY: CARING

RT 86 .B469	Benner, Patricia and Judith Wrubel. The Primacy of Caring: Stress & Coping in Health and Illness, Reading, MA: Addison-Wesley 1988
RT 84.5 .W339	Watson, Jean. Nursing: The Philosophy & Science of Caring. Boulder, Colorado:Colorado Associated University Press 1985
RT 84.5 .W339n	Watson, Jean. Nursing: Human Science and Human Care, Boulder, Colorado:Colorado Associated University Press 1988

CHIPPEWA VALLEY TECHNICAL COLLEGE
ASSOCIATE DEGREE NURSING

Graduate Competencies

Care-Giver Role

1.0 Apply psychomotor and cognitive skills derived from biopsychosocial and nursing theory to meet health needs of individuals and families by:

    1.1 Collecting data for assessment in a systematic manner.

    1.2 Identifying appropriate nursing diagnoses.

    1.3 Utilizing clients' potential strengths in formulating desired outcomes.

    1.4 Individualizing plans of care based on standardized protocols.

    1.5 Implementing nursing care plans based on nursing diagnoses that include nursing interventions and outcome criteria.

    1.6 Evaluating and modifying nursing interventions based on clients' responses to the attainment of outcome criteria.

    1.7 Collaborating with members of other disciplines.

    1.8 Maintaining a safe, therapeutic environment.

Client Teacher Role

2.0 Apply principles from the teaching-learning process to assist individuals within families to promote health practices, prevent illness, cope with stressors and adapt to changes in health status by:

    2.1 Assessing client/family learning needs.

    2.2 Developing individualized teaching plans.

    2.3 Implementing teaching stratetgies for individuals and small groups.

    2.4 Evaluating effectiveness of client teaching.

    2.5 Documenting the client/family progress throughout the teaching-learning process.

    2.6 Sharing clinical knowledge and skills with colleagues

Manager of Care Role

3.0 Interact with members of the health team to manage care for groups of clients in a structured setting by

- 3.1 Establishing nursing care priorities.
- 3.2 Directing personnel of equal or lesser educational preparation in selected aspects of care.
- 3.3 Collaborating with other health care providers.
- 3.4 Organizing time and resources in a cost-effective manner.
- 3.5 Participating in developing and revising nursing unit policies and procedures.
- 3.6 Using proper channels of communication to maintain flow of information and ideas.

Investigator Role

4.0 Appreciates the relevance of clinical research studies to nursing practice by:

- 4.1 Understanding the goals and general methods of research.
- 4.2 Participating in research studies within an established framework.
- 4.3 Assisting in identifying (nursing) research problems that need to be studied.
- 4.4 Utilizing the problem-solving approach in nursing practice.

Member of Discipline

5.0 Accept the responsibilities as a member of the discipline of nursing by:

- 5.1 Demonstrating the technical level of nursing practice within the health care delivery system.
- 5.2 Demonstrating accountability for own nursing practice.
- 5.3 Practicing within the legal and ethical parameters of the nursing profession.
- 5.4 Protecting clients' rights.
- 5.5 Participating in professional nursing and community organizations.
- 5.6 Assuming responsibility for self development.

ADN Faculty Rev/1-88
GradCompetencies

CRITICAL THINKING: OBJECTIVES

Graduate Competencies

Investigator Role

4.0 Develops the habit of rational thinking by
  4.1 Exhibiting relevant dispositions.
  4.2 Analyzing issues logically and fairly.
  4.3 Producing creative solutions for nursing problems.
  4.4 Demonstrating ethical decision-making.

Level Competencies

Level I

Investigator Role

4.0 Acquaints self with strategies of rational thinking by
  4.1 Recognizing characteristics of fairmindedness.
  4.2 Demonstrating sensitivity to nursing issues.
  4.3 Demonstrating willingness to explore novel solutions to problems.
  4.4 Acquainting self with current ethical dilemmas in nursing.

Level II

Investigator Role

4.0 Actively seeks opportunities to utilize rational thinking by
  4.1 Exhibiting intellectual curiosity.
  4.2 Developing a position on nursing issues based on evidence.
  4.3 Actively seeking imaginative solutions to problems.
  4.4 Applying criteria for evaluation of ethical dilemmas.

LEVEL OBJECTIVES: CAREGIVER ROLE

LEVEL I	LEVEL II	LEVEL III
1.0 Apply psychomotor and cognitive skills derived from biopsychosocial and nursing theory to meet basic health needs of individuals by:	1.0 Apply psychomotor and cognitive skills derived from biopsychosocial and nursing theory to meet basic health needs of individuals and their families by:	1.0 Apply psychomotor and cognitive skills derived from biopsychosocial and nursing theory to meet complex health needs of individuals and their families by:
1.1 Collecting assessment data in a systematic manner	1.1 Collecting assessment data in a systematic manner	1.1 Collecting assessment data in a systematic manner
1.2 Identifying appropriate nursing diagnosis with assistance	1.2 Identifying appropriate nursing diagnoses	1.2 Identifying appropriate nursing diagnoses
	1.3 Formulating desired outcomes based on clients' potential strengths with assistance	1.3 Utilizing clients' potential strengths in formulating desired outcomes
	1.4 Individualizing plans of care based on standardized protocols	1.4 Individualizing plans of care based on standardized protocols
1.5 Implementing selected aspects of nursing care	1.5 Implementing nursing care plans	1.5 Implementing nursing care plans
	1.6 Evaluating and modifying nursing interventions based on clients' responses to the attainment of outcome criteria	1.6 Evaluating and modifying nursing interventions based on clients' responses to the attainment of outcome criteria
	1.7 Interacting with member of other disciplines	1.7 Collaborating with members of other disciplines
1.8 Maintaining a safe environment	1.8 Maintaining a safe, therapeutic environment	1.8 Maintaining a safe, therapeutic environment

LEVEL OBJECTIVES: CLIENT TEACHER ROLE

LEVEL I	LEVEL II	LEVEL III
2.0 Understand role of nurse as client teacher as evidenced by: a. participating in incidental teaching b. reinforcing existing teaching plans	2.0 Apply principles from the teaching-learning process to assist individuals with predictable health care needs by:	2.0 Apply principles from the teaching-learning process to assist individuals to promote health practices, prevent illness, cope with stressors and adapt to changes in health status by:
	2.1 Assessing client/family learning needs, readiness, ability and barriers to learning with assistance	2.1 Assessing client/family's learning needs, readiness, ability and barriers to learning
	2.2 Developing individualized teaching plans with assistance	2.2 Developing individualized teaching plans
	2.3 Implementing teaching strategies for individuals and small groups	2.3 Implementing teaching strategies for individuals and small groups
	2.4 Evaluating effectiveness of client teaching	2.4 Evaluating effectiveness of client teaching
	2.5 Recognizing need for referral to community agencies for continued learning needs	2.5 Referring to appropriate agencies for continuing learning needs
	2.6 Documenting the client/family progress throughout the teaching-learning process	2.6 Documenting the client/family progress throughout the teaching-learning process
	2.7 Sharing clinical knowledge and skills with peers	2.7 Sharing clinical knowledge and skills with colleagues

LEVEL OBJECTIVES: MANAGER OF CARE ROLE

LEVEL I	LEVEL II	LEVEL III
3.0 Manage basic care for individual clients in a structured setting by:	3.0 Manage care for individual clients in a structured setting by:	3.0 Interact with members of of the health team to manage care for groups of clients in a structured setting by:
	3.1 Establishing nursing care priorities	3.1 Establishing nursing care priorities
		3.2 Directing personnel of equal or lesser educational preparation in selected aspects of care
	3.3 Interacting with other health care providers	3.3 Collaborating with health care providers
3.4 Organizing time and resources	3.4 Organizing time and resources	3.4 Organizing time and resources in a cost-effective manner
		3.5 Participating in developing and revising nursing unit policies and procedures
3.6 Using proper channels of communication to maintain flow of information and ideas	3.6 Using proper channels of communication to maintain flow of information and ideas	3.6 Using proper channels of communication to maintain flow of information and ideas

LEVEL OBJECTIVES: INVESTIGATOR ROLE

LEVEL I	LEVEL II	LEVEL III
4.0 Demonstrate receptiveness to new information by:	4.0 Appreciate the relevance of clinical research studies to nursing practice by:	4.0 Appreciates the relevance of clinical research studies to to nursing practice by:
4.1 Reviewing resources relevant to client care	4.1 Understanding the goals and general methods of research	4.1 Understanding the goals and general methods of research
4.2 Identifying news reports relating to research in health care		4.2 Demonstrating a willingness to participate in research studies within an established framework
		4.3 Assisting in identifying research problems that need to be studied
	4.4 Utilizing the problem-solving approach in nursing practice	4.4 Utilizing the problem-solving approach in nursing practice

LEVEL OBJECTIVES: MEMBER OF DISCIPLINE ROLE

LEVEL I	LEVEL II	LEVEL III
5.0 Accept the responsibilities as a member of the discipline of nursing by:	5.0 Accept the responsibilities as a member of the discipline of nursing by:	5.0 Accept the responsibilities as a member of the discipline of nursing by:
		5.1 Demonstrating the technical level of nursing practice within the health care delivery system
5.2 Demonstrating accountability for own nursing practice	5.2 Demonstrating accountability for own nursing practice	5.2 Demonstrating accountability for own nursing practice
5.3 Practicing within the legal and ethical parameters of the nursing profession	5.3 Practicing within the legal and ethical parameters of the nursing profession	5.3 Practicing within the legal and ethical parameters of the nursing profession
5.4 Protecting clients' rights	5.4 Protecting clients' rights	5.4 Protecting clients' rights
		5.5 Participating in professional nursing and community organizations
	5.6 Assuming responsibility for self development	5.6 Assuming responsibility for self development
	5.7 Understanding responsibilities of employee of a health care agency	5.7 Accepting responsibilities of employee of a health care agency

LevelObjectives
Rev1-88/ADN Faculty

EXHIBIT B

ABOUT THIS PROGRAM

Associate Degree Nursing (Technical Nursing) is a two-year program at Chippewa Valley Technical College. The courses are sequenced to build on knowledge and skills acquired in prior learning and form linkages to nursing activities, roles and responsibilities. Learning situations in the classroom, nursing laboratory and clinical settings are designed to stimulate dialogue and provide structure where students learn to articulate and defend their selection of facts, principles and concepts used in solving problems and making decisions in the delivery of nursing care.

Graduates of the program are granted an Associate Degree in Applied Science. They are eligible to write the National Licensure Examination for Registered Nurse. Graduates who are successful then assume the privileged role of "registered nurse". This program is approved by the Wisconsin Board of Vocational Technical and Adult Education and the State of Wisconsin Board of Nursing. National accreditation is held through the National League for Nursing, New York.

THE CAREER

Nursing is the dynamic interpersonal process which seeks to facilitate the promotion, maintenance, and restoration of health. Nursing seeks to facilitate the development of the client's ability to adapt. The nurse assists clients to meet their needs and makes nursing decisions by:

a) collecting, verifying, and communicating data about a client, including a nursing assessment and data base.
b) analyzing, interpreting, identifying problems and formulating nursing diagnoses.
c) establishing priorities and goals and formulating a plan of care.
d) initiating nursing interventions to achieve these goals.
e) measuring the client's response to nursing acts and progress toward goal achievement.

The associate degree nurse also performs delegated acts including treatments and administration of pharmaceuticals.

EMPLOYMENT

The registered nurse works within a complex health care delivery system which requires collaboration with other disciplines providing care. Nurses have a wide range of career choices including acute and long-term health care settings, health clinics, industry, medical supply companies, publishing firms, emergency services, rehabilitation centers, and the armed services.

ADMISSIONS/COSTS

Requirements for admission to the Associate Degree Nursing Program are high school level proficiency in English, Biology, Algebra, and Chemistry. A grade of "C" or above, completed in the last seven (7) years, meets the proficiency requirement. Students who desire a review have the option to enroll in mini-refresher courses. Prior to admission, all applicants must attend an orientation session conducted by Nursing Division staff.

Enrollees with transcripts that reflect lack of or outdated course work will meet with an advisor to develop a plan to complete the proficiency requirements. Several measures of assessment are used to gather meaningful information in order to select the most appropriate academic plan.

THE PROGRAM OF STUDY

Track I

		Hrs/Wk	Credits
June: 8 week summer session			
806-125	*General Chemistry	10	4
809-115	Psychology of Human Relations	6	3
801-151	Communication Skills I	6	3
		22	10
August: 18 week semester			
510-101	^+*Nursing Skills I	3	1
809-130	*Developmental Psychology	3	3
806-140	*Anatomy & Physiology	5	4
806-132	*Microbiology	4	3
510-114	+*Nursing Skills II	3	1
510-110	^+~Introduction to Nursing	5	3
		23	15
January: 18 week semester			
510-115	+*Nutrition for Nursing Practice	2	2
510-122	+*Pathophysiology I	2	2
510-130	+*Pharmacology	2	2
510-150	+*Intermediate Nursing	4	3
510-151	+*Intermediate Nursing Practice I	9	2
	Elective	3	3
		22	14
June: 8 week summer session			
510-123	*Pathophysiology II	4	2
510-153	*Intermediate Nursing Practice II	18	3
510-132	*Nursing Skills III	6	1
		28	6
August: 18 week semester			
809-103	Introduction to Sociology	3	3
	Elective	3	3
510-160	*Advanced Nursing I	3	2
510-161	*Advanced Nursing Practice I	12	4
		21	12
January: 18 week semester			
12 weeks			
510-162	*Advanced Nursing II	2	2
510-163	*Advanced Nursing Practice II (6 weeks) \		2
510-170	*Patient Care Management (6 weeks) /	19	3
801-153	*Technical Reporting	3	3
		24	
6 weeks			
510-171	*Nursing Practice Internship	36	3
			13

All students have the opportunity to demonstrate proficiency and receive credit for general education courses. Information is available through the Admissions Office.

Students with prior learning in nursing have the option to demonstrate proficiency and receive credit for some of the nursing courses. Information is available through the Nursing Division.

*Course has prerequisite
~Proficiency options for all students
^Proficiency options for Nursing Assistants
+Proficiency options for Licensed Practical Nurses

TRACK II

		Hrs/Wk	Credits
January: 18 week semester			
806-125	*General Chemistry	5	4
809-115	Psychology of Human Relations	3	3
801-151	Communication Skills I	3	3
806-140	*Anatomy & Physiology	5	4
510-101	^+~Nursing Skills I	3	1
510-114	+*Nursing Skills II	3	1
		22	16
June: 8 week summer session			
809-130	*Developmental Psychology	6	3
510-110	^+~Introduction to Nursing	10	3
		16	6
August: 18 week semester			
806-132	*Microbiology	4	3
510-122	+*Pathophysiology I	2	2
510-130	+*Pharmacology	2	2
510-115	+*Nutrition for Nursing Practice	2	2
510-150	+*Intermediate Nursing	4	3
510-151	+*Intermediate Nursing Practice I	6	2
		20	14
January: 18 week semester			
510-153	*Intermediate Nursing Practice II	9	3
809-103	Introduction to Sociology	3	3
	Elective	3	3
510-132	*Nursing Skills III	3	1
510-160	*Advanced Nursing I	3	2
510-123	*Pathophysiology II	2	2
		23	14
June: 8 week summer session			
510-161	*Advanced Nursing Practice I	24	4
	Elective	6	3
		30	7
August: 18 week semester			
12 weeks			
510-162	*Advanced Nursing II	2	2
510-163	*Advanced Nursing Practice II (6 weeks)		2
510-170	*Patient Care Management (6 weeks)	19	3
801-153	*Technical Reporting	3	3
		24	
6 weeks			
510-171	*Nursing Practice Internship	36	3
			13

All students have the opportunity to demonstrate proficiency and receive credit for general education courses. Information is available through the Admissions Office.

Students with prior learning in nursing have the option to demonstrate proficiency and receive credit for some of the nursing courses. Information is available through the Nursing Division.

*Course has prerequisite
~Proficiency options for all students
^Proficiency options for Nursing Assistants
+Proficiency options for Licensed Practical Nurses

TECHNICAL NURSING

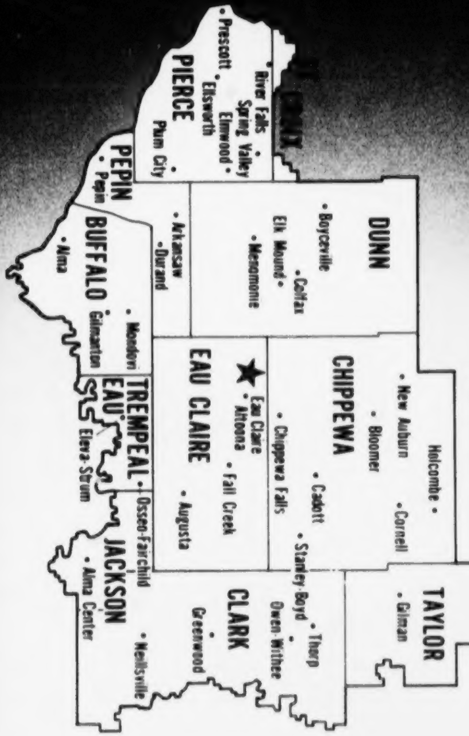
A HEALTH DIVISION PROGRAM

Chippewa Valley Technical College
620 W. Clairemont Ave. • Eau Claire, Wisconsin

Chippewa Valley Technical College
620 W. Clairemont • Eau Claire, WI
715-833-6200 54701-1098

For more information contact the Student Services Department. We are open 7:30 a.m. to 4:30 p.m. weekdays. Phone us at (715) 833-6242.

Chippewa Valley Technical College district



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PIERCE
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ABOUT THIS PROGRAM

Associate Degree Nursing (Technical Nursing) is a two-year program at Chippewa Valley Technical College. The courses are sequenced to build on knowledge and skills acquired in prior learning and form linkages to nursing activities, roles and responsibilities. Learning situations in the classroom, nursing laboratory and clinical settings are designed to stimulate dialogue and provide structure where students learn to articulate and defend their selection of facts, principles and concepts used in solving problems and making decisions in the delivery of nursing care.

Graduates of the program are granted an Associate Degree in Applied Science. They are eligible to write the National Licensure Examination for Registered Nurse. Graduates who are successful then assume the privileged role of "registered nurse". This program is approved by the Wisconsin Board of Vocational Technical and Adult Education and the State of Wisconsin Board of Nursing. National accreditation is held through the National League for Nursing, New York.

THE CAREER

Nursing is the dynamic interpersonal process which seeks to facilitate the promotion, maintenance, and restoration of health. Nursing seeks to facilitate the development of the client's ability to adapt. The nurse assists clients to meet their needs and makes nursing decisions by:

a) collecting, verifying, and communicating data about a client, including a nursing assessment and data base.
b) analyzing, interpreting, identifying problems and formulating nursing diagnoses.
c) establishing priorities and goals and formulating a plan of care.
d) initiating nursing interventions to achieve these goals.
e) measuring the client's response to nursing acts and progress toward goal achievement.

The associate degree nurse also performs delegated acts including treatments and administration of pharmaceuticals.

THE PROGRAM OF STUDY

Track I

Course No.	Course Title	Hrs./Wk.	Credits
June: 8 week summer session			
806-125	General Chemistry*	10	4
809-115	Psychology of Human Relations	6	3
801-151	Communication Skills I	6	3
		22	10
August: 18 week semester			
510-101	Nursing Skills I ◄+*	3	1
809-130	Developmental Psychology*	3	3
806-140	Anatomy & Physiology*	5	4
806-132	Microbiology*	4	3
510-114	Nursing Skills II +*	3	1
510-110	Introduction to Nursing ◄+‡	5	3
		23	15
January: 18 week semester			
510-115	Nutrition for Nursing Practice +*	2	2
510-122	Pathophysiology I +*	2	2
510-130	Pharmacology +*	2	2
510-150	Intermediate Nursing +*	4	3
510-151	Intermediate Nursing Practice I +*	9	2
	Elective	3	3
		22	14
June: 8 week summer session			
510-123	Pathophysiology II*	4	2
510-153	Intermediate Nursing Practice II*	18	3
510-132	Nursing Skills III*	6	1
		28	6
August: 18 week semester			
809-103	Introduction to Sociology	3	3
510-160	Advanced Nursing I*	3	2
510-161	Advanced Nursing Practice I*	12	4
	Elective	3	3
		21	12
January: 18 week semester			
12 weeks			
510-162	Advanced Nursing II*	2	2
510-163	Advanced Nursing Practice II* (6 weeks)		2
510-170	Patient Care Management* (6 weeks)	19	3
801-153	Technical Reporting*	3	3
		24	
6 weeks			
510-171	Nursing Practice Internship*	36	3
			13

Track II

Course No.	Course Title	Hrs./Wk.	Credits
January: 18 week semester			
806-125	General Chemistry*	5	4
809-115	Psychology of Human Relations	3	3
801-151	Communication Skills I	3	3
806-140	Anatomy & Physiology*	5	4
510-101	Nursing Skills I ◄+‡	3	1
510-114	Nursing Skills II +*	3	1
		22	16
June: 8 week summer session			
809-130	Developmental Psychology*	6	3
510-110	Introduction to Nursing ◄+‡	10	3
		16	6
August: 18 week semester			
806-132	Microbiology*	4	3
510-122	Pathophysiology I +*	2	2
510-130	Pharmacology +*	2	2
510-115	Nutrition for Nursing Practice +*	2	2
510-150	Intermediate Nursing +*	4	3
510-151	Intermediate Nursing Practice I +*	6	2
		20	14
January: 18 week semester			
510-153	Intermediate Nursing Practice II*	9	3
809-103	Introduction to Sociology	3	3
510-132	Nursing Skills III*	3	1
510-160	Advanced Nursing I*	3	2
510-123	Pathophysiology II*	2	2
	Elective	3	3
		23	14
June: 8 week summer session			
510-161	Advanced Nursing Practice I*	24	4
	Elective	6	3
		30	7
August: 18 week semester			
12 weeks			
510-162	Advanced Nursing II*	2	2
510-163	Advanced Nursing Practice II* (6 weeks)		2
510-170	Patient Care Management* (6 weeks)	19	3
801-153	Technical Reporting*	3	3
		24	
6 weeks			
510-171	Nursing Practice Internship*	36	3
			13

*Course has prerequisite
‡ Proficiency options for all students
◄ Proficiency options for Nursing Assistants
+ Proficiency options for Licensed Practical Nurses

All students have the opportunity to demonstrate proficiency and receive credit for general education courses. Information is available through the Admissions Office.

Students with prior learning in nursing have the option to demonstrate proficiency and receive credit for some of the nursing courses. Information is available through the Nursing Division.

EMPLOYMENT

The registered nurse works within a complex health care delivery system which requires collaboration with other disciplines providing care. Nurses have a wide range of career choices including acute and long-term health care settings, health clinics, industry, medical supply companies, publishing firms, emergency services, rehabilitation centers, and the armed services.

ADMISSIONS/COSTS

Requirements for admission to the Associate Degree Nursing program are high school level proficiency in English, biology, algebra, and chemistry. A grade of "C" or above, completed in the last seven (7) years, meets the proficiency requirement. Students who desire a review have the option to enroll in mini-refresher courses. Prior to admission all applicants must attend an orientation session conducted by the Nursing Division staff.

Enrollees with transcripts that reflect lack of or outdated course work will meet with an advisor to develop a plan to complete the proficiency requirements. Several measures of assessment are used to gather meaningful information in order to select the most appropriate academic plan.

All applicants must have a completed application into the Admissions Office before they are accepted in a program at Chippewa Valley Technical College. A "completed" application includes: completion of the statewide application form, payment of a $30 advance admission fee, and receipt of a high school grade transcript by the Admissions Office.

Chippewa Valley Technical College operates on a "first come, first serve" basis for admitting students. Additional academic requirements may be necessary for entrance into some training programs. For additional program enrollment information contact:

Admissions Office
Chippewa Valley Technical College
620 West Clairemont Avenue
Eau Claire, WI 54701

Costs may vary each year and include such items as tuition, material fees, an activity fee, books and supplies. Latest program costs are available through the school's Student Services Department.

Out-of-district students must pay an additional tuition. If you are a Wisconsin resident of another VTAE District that does not offer this program, you should check with your local district regarding payment of the nonresident tuition by that district.

In addition, many types of financial aids are available through the Technical College. Available student financial aid includes grants, loans, and work-study. Applications for student financial aid should be completed at least 16 weeks before the start of class.

For further information:
PHONE: (715) 833-6242
Student Services Department
HOURS: 7:30 a.m. to 4:30 p.m. weekdays

COMPLIANCE STATEMENT

Chippewa Valley Technical College is in full compliance with Titles VI and VII of the 1964 Civil Rights Act, Title IX of the 1972 Education Amendments, and the Rehabilitation Act of 1973. It is the policy of the District not to discriminate on the basis of sex, race, color, national origin, religion, political belief, age, handicap, sexual orientation, or record of arrest or conviction in its educational programs, admissions, activities, or employment policies. Inquiries regarding compliance with the above named regulations may be directed to the Affirmative Action Officer, Title IX and 504 Coordinator, Main Building, Chippewa Valley Technical College, 620 West Clairemont Avenue, Eau Claire, Wisconsin 54701. (Telephone: 715-833-6257).

EXHIBIT C

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

COURSE DESCRIPTIONS
New ADN Curriculum

510-101 Nursing Skills I, Credits: 1, 1:3 = 54 hours CBI
Prerequisites: Acceptance in program.
Challenge Options: All nursing program enrollees.

This competency-based course includes medical terminology and the demonstration or development of the basic motor skills needed to provide safe care to patients. The skills are learned through a variety of methods outlined in individual learning packets and are evaluated by an instructor for competence. Students must demonstrate competency in all of the motor skills before progressing to Section III of 510-110 Introduction to Nursing.

510-110 Introduction to Nursing, Credits: 3, 2 credits 1:1 = 36 hrs. theory, 1 credit 1:3 = 54 hrs.clinical practice.
Prerequisites: Completion of or concurrent enrollment in 510-101 Nursing Skills I.

Section I Theory = 1 credit challenge options NA, LPN.
Section II Theory = 1 credit challenge options LPN.
Section III Clinical = 1 credit challenge options NA, LPN.
Advanced standing students may take this course concurrently with 510-114 Nursing Skills II.

The goal of this course is to build on knowledge and skills acquired in prior learning experiences in order to provide a basis for understanding basic nursing practice. Psychosocial, behavioral, biological, cultural, and spiritual concepts provide the theoretical background that serves to sensitize the student to the unique needs of each patient and the role of the nurse as a provider of care. Scientific principles and ethical-legal guidelines for behaviors give direction for maintaining a safe, supportive patient care environment. Opportunities to actively seek imaginative solutions to problems and develop question-asking skills are provided in simulated and actual situations.

510-114 Nursing Skills II, Credits: 1, 1:3 = 54 hrs CBI
Prerequisites: completion of or concurrent enrollment in 510-110 Introduction to Nursing.
Challenge options: LPNs.

This competency-based course includes the demonstration or development of more advanced motor skills involving sterile technique, administration of medication, dressing changes, treatments, irrigations and handling hazardous waste. Skills are developed through a variety of methods designed for self-directed learning activities as outlined in individual learning packets and evaluated by faculty for competence. This course may be completed before or concurrently with 510-150 Intermediate Nursing and 510-151 Intermediate Nursing Practice I.

510-115 Nutrition for Nursing Practice, Credits: 2, 1:1 = 36 hrs. theory
Prerequisites: 806-125 General Chemistry
806-140 Anatomy & Physiology
806-132 Microbiology

Study of basic principles of nutrition and hydration which underlie nursing assessment, diagnosis, and intervention in relation to the health patterns of the developing person. The course focuses particularly on the nutrition/metabolic pattern. Includes overview of nutrients and normal functions of nutrients and fluids in the body with emphasis on the changing needs of individuals as they progress through the life span. Also addressed are modified diets and nutritional therapies as methods of promoting nutritional intake for persons with special needs.

510-122 Pathophysiology I, Credits: 2, 1:1 = 36 hours theory
Prerequisites: 806-125 General Chemistry
806-140 Anatomy & Physiology
806-132 Microbiology

This course is designed to increase the student's knowledge of physiologic and pathologic mechanisms which influence a person's dynamic health status. Disease agents and situations as well as the body's adaptive responses to these stressors are examined in order to increase understanding of the complex concept of homeostasis as it contributes to positive health. This course is part of a two course sequence and specific areas of study in this course include: cellular functions and growth, body defense mechanisms, oxygenation, and fluid, electrolyte, and body waste balance. This course builds upon concepts previously learned in Chemistry, Anatomy and Physiology, and Microbiology.

510-130 Pharmacology, Credits: 2, 1:1 = 36 hours theory
Prerequisites: 806-125 General Chemistry
806-140 Anatomy & Physiology
806-132 Microbiology

Students will study the basic pharmodynamics and pharmokinetics of the major drug classifications. The nursing process will be utilized when examining the nurse's role and responsibilities of drug therapy across the life span. The student will explore the psychosocial-cultural and legal-ethical issues related to drug therapy. Specific concepts will include calculating medication dosages.

510-150 Intermediate Nursing, Credits: 3,
2 credits 1:1 = 36 hrs. theory, 1 credit 1:2 = 36 hrs. Lab
Prerequisites: completion of all prior summer/semester courses.

This course occurs at a point within the curriculum where student knowledge of nursing acts is linked to comprehension of nursing roles and responsibilities. The course focus reinforces the concepts of person, health, illness, and humane caring while expanding student perception through exploration and use of systematic thinking patterns. Specifically, the nursing process and the teaching/learning process explore the components of both processes, with application expected in simulated situations. Two overarching key concepts of nursing function are introduced: the ability of the nurse to relate to the client therapeutically, and the ability of the nurse to think critically in making sound judgments which affect the client's well-being.

The laboratory component is designed for group practice in developing teaching/learning plans for patients, simulations of therapeutic interactions, and learning the nursing process by developing care plans that lead to the safe resolution of patient-centered problems. Through participation in groups to achieve these competencies, the student learns some of the dynamics of group process.

510-151 **Intermediate Nursing Practice I, Credits: 2, 1:3 = 108 hours clinical practice.**
Prerequisites: completion of all prior summer/semester courses.

This course is taught concurrently with "Intermediate Nursing Theory". It occurs within a clinical environment where facts, concepts and principles presented in the theory course can be further recalled, articulated, refined, and thus digested as part of the future nurse's competency repertoire. It further invites students to explore the nurse's work environment and begin to develop a vision of "self" as a member of the discipline of nursing within such settings. Opportunities to develop sound decision making abilities and communicate caring attitudes are promoted in the delivery of services to patients and their families.

510-123 **Pathophysiology II, Credits: 2, 1:1 = 36 hours theory**
Prerequisites: 510-122 Pathophysiology I

This course is a continuation of Pathophysiology I. It's purpose is to continue to expand on the student's understanding of the factors which support and detract from homeostasis. Specifically the course focuses on endocrine, metabolism, and nutrition processes; neuromuscular function; skeletal function and body movement; and function of the reproductive systems.

510-153 **Intermediate Nursing Practice II, Credits: 3, 1:3 = 162 hours 6 clinical practice.**
Prerequisites: completion of all prior summer/semester courses.

In the preceding clinical course an application environment was provided for students to try out systematic thinking patterns. The present course offers an expanded time frame for continued application and practice. In addition, while continuing to use the same familiar environment, it provides opportunity to link knowledge obtained in other concurrent nursing courses to the clinical setting. The desired result is student competence which will consistently broaden and deepen. Competency will be demonstrated by effective therapeutic interaction which allows the student to: increase their depth of data collection, accurately determine and prioritize multiple nursing diagnosis, and, as a result, develop, implement, evaluate and revise holistic, ongoing plans of care. Consequently, actual and potential nursing diagnosis will be addressed, use of the teaching/learning process as a method of nursing intervention will be incorporated, and patient participation in the planning process will be understood as essential for success. Familiarization with the work environment is also expected to deepen.

510-132 **Nursing Skills III, Credits: 1, 1:3 = 54 hours CBI**
Prerequisites: completion of all prior summer/semester courses.

Advanced motor skills are developed in this competency-based course. Using a variety of methods that emphasize self-directed learning, the student learns intravenous therapy, central line care, tracheostomy care, and physical assessment techniques. Students are expected to articulate the rationale for these procedures and discriminate between barriers and precautions when initiating/performing a procedure. These procedures are evaluated for competence in the laboratory by faculty. This course may be taken concurrently with 510-160 Advanced Nursing I and during the first four weeks of 510-161 Advanced Nursing Practice I.

510-160 **Advanced Nursing I, Credits: 2, 1:1 = 18 hours theory, 1:2 = 36 hours lab.**
Prerequisites: completion of all prior summer/semester courses.

Learning situations are designed to provoke dialogue and facilitate an understanding of the culture-gender roles, relationships and responsibilities carried by the patient who experiences an interruption in his/her health state. A clear theoretical base that explores mental health and mental health problems across the life span enables the student to articulate the nursing process to these health states. Readings in which different writers take different positions in ethical decisions are assigned to facilitate the student's recognition of the logical components of his/her own beliefs. Therapeutic communication simulations foster the creative exploration of how caring behaviors are manifested within various age groups. The characteristics of group functioning are explored in terms of practical consequences. Mechanisms of actions of hazards within the human being provide problem solving opportunities where students further develop their ability to process information individually and in groups. Using simulated patient care situations, opportunities to refine interview techniques and assess functional health patterns enables the student to connect theoretical concepts to representations of these concepts.

510-161 **Advanced Nursing Practice I, Credits: 4, 1:3 = 216 hours clinical practice**
Prerequisites: completion of all prior summer/semester courses.

This course is taught concurrently with Advanced Nursing I. Students are guided to reflect on their own thinking processes as they explore interdisciplinary alternatives that may interface with the practices of other health care providers. For collaborative problems, students are guided to identify and implement interventions that are in the domain of nursing. The focus on clinical decision-making skills to particular problems specific to various age groups promotes the inclusion of concepts from behavioral and natural sciences in the development of teaching/learning plans. Students are coached to expand the therapeutic use of self to an empathic awareness of the patient's perspective of his/her experience of pain, grief, suffering or anger. Because of the expanded clinical time frame, opportunities for multiple assignments promote a more refined development of the ability to set priorities and accomplish all aspects of the nursing process.

510-162 **Advanced Nursing II, Credits: 2, 1:1 = 36 hours theory**
Prerequisites: completion of all prior summer/semester courses.

Nursing diagnosis and physical and psychosocial assessment skills are refined, articulated and adapted to a wider and more complex range of health deviations. Computer software programs provide self-paced alternative learning opportunities where students explore their judgment and ability to carry out the nursing process using data representative of diverse populations. Case presentations by students will assist faculty to assess the student's ability to apply past and current concepts, think critically, solve problems, recognize ethics and cultural variations and articulate their ideas clearly.

510-163 **Advanced Nursing Practice II, Credits: 2, 1:3 = 108 hours clinical practice.**
Prerequisites: completion of all prior summer/semester courses.

The purpose of this course is to provide structure to clinical learning experiences where students learn to articulate and defend their selection of facts, principles and concepts used in making decisions. Students are expected to consider the environment and to use more complete and sophisticated age and culture specific descriptions of clinical data in the formulation of care plans for patients with multiple and complex problems. Clinical instructors nuture analytical thinking in challenging the student to break down the component parts of the patient's situation and formulate an intellectual model that can be used to articulate the situation as a whole from more than one perspective. The concepts of caring is expanded to more accurate assessment of reactions and interactions and include the recognition of the nurse's intuitive sense in clinical practice.

510-170 **Patient Care Management, Credits: 3, 1 - 1:1 = 18 hours theory, 2 - 1:3 = 108 hours clinical practice.**
Prerequisites: completion of all prior summer/semester courses.

This course is designed to enable students to acquire skills in coordi-nating human resources to manage the care of groups of patients. Learn-ing directives assume that students are able to internalize and integrate concepts, facts and principles from prior courses to concepts in manage-ment. Ethical reasoning skills are applied to simulated and actual situ-ations that consider the views of patients, families and caregivers. Accountability for own practice and the practice of ancillary personnel is addressed in terms of choices the nurse has in his/her control of the practice environment. Learning activities direct students to act as patient advocates by assisting patients to interface with human and nonhuman elements in the clinical care setting, such as the data base, patient care procedures, and decision-making. Students process and communicate information in collaborative relationship using advanced technology.

510-171 **Nursing Practice Internship, Credits:** 3, 1:72 = 216 clinical **practice hours.**
Prerequisites: completion of all prior summer/semester courses.

This course is designed to provide more access to patient care in order to further develop student's management skills and enhance their clinical data base for making clinical decisions. Placement in local and rural health care settings will provide opportunities for students to acquire situational experience with special populations of their choice and move from novice to a more advanced state for beginning practice.

Clinical learning experiences will occur through collaborative relationships with selected staff nurses who will serve as preceptors under the direction and supervision of the clinical instructor. The learning activities will be monitored through weekly conferences involving the clinical instructor, preceptor and student and through weekly seminars on the main or branch campus.

7-89/bh
CDescrips

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

CLINICAL PRACTICE PLACEMENT

The introduction of the students to the clinical practice setting occurs during the last ten weeks of Introduction to Nursing. Students apply nursing concepts in various acute and long-term health care settings. Observational experiences in supportive services enrich the student's understanding of resources available to patients in the community. Specifically the student applies nursing practice skills in these settings.

Introduction to Nursing

Geriatrics - long term care

Intermediate Nursing Practice I

Birth Center - family centered nursing
Surgical Units - various age groups
Support Services - prenatal clinics, adult clinic, cultural variations, home care

Intermediate Nursing Practice II

Surgical Units - acute care setting
Medicare Units - long term care setting
Support Services - home care, clinics, day care for elder

Advanced Nursing Practice I

Medical Units - adults, children, adolescents
Pediatric Units - children
Psychiatric Units - adults, children
Psychogeriatric Units - elder
Support Services - clinics, assessment, well child clinics, day care centers

Advanced Nursing Practice II

Medical Units - adults, elders
Critical Care Units - adults, elders
Surgical Units - adults, elders
Intensive Care Units - adults, elders
Medicare Units - nursing homes
Support Services - clinic services develop disabled

Patient Care Management

Medical Units - all age groups
Surgical Units - all age groups
Special Care Units - all age groups

Nursing Practice Internship

Local and rural acute and long term health care units. Some options for students to select specialty areas.

7-89/bh/CDescrips

EXHIBIT D

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN

CHALLENGE EXAMINATION INFORMATION FOR DEMONSTRATION OF PROFICIENCY BY NURSING ASSISTANTS

SECTION I--INTRODUCTION TO NURSING

Written Examination

Following registration nursing assistants have the option to demonstrate mastery of the content of Section I--Introduction to Nursing. Your study guide is the course outline (which includes the objectives) of Section I--Introduction to Nursing. The examination must be taken prior to the beginning of the class. Students who wish to challenge this component of the course must make an appointment to take the examination by calling the Nursing Laboratory (715) 833-6396. If successful on this examination, you will not need to participate in theory classes during the first nine weeks of the course, 510-110 Introduction to Nursing.

MASTERY SKILL DEMONSTRATION OF COMPETENCY IN 510-101 NURSING SKILLS I

The Nursing Skills I packet is the outline and study guide for demonstration of competency in Nursing Skills I. Nursing Laboratory (P204) instructors are available to clarify the information related to the challenge process. The mastery of skills challenge should be completed by the third week of the first semester of the program.

MASTERY SKILL DEMONSTRATION OF COMPETENCY IN CLINICAL SKILLS SECTION III-A, 510-110 INTRODUCTION TO NURSING

Nursing assistants who feel they have mastered the introductory clinical competencies may test out of the clinical component of 510-110 Introduction to Nursing. The guidelines for the clinical challenge are available through the Lead Instructor. The clinical challenge must be completed before the 9th week of the first semester of the program. Students who successfully pass the clinical challenge are not required to attend the clinical sessions during the first four weeks of the eight week clinical rotation.

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING
CHALLENGE EXAM SECTION I

Directions: This exam consists of 70 items. Select the best response and using a #2 lead pencil fill in completely the lettered box on the answer sheet corresponding to the response you have chosen. Please read the items carefully and choose the best answer.

PERSONAL CARE SKILLS

1. Oral hygiene for the resident with dentures must include:

   a. brushing of dentures.
   b. rinsing the mouth.
   c. cleaning of cheeks, tongue and roof of the mouth
   d. all of the above.

2. You are assigned to give morning care to Mrs. M., an 80-year-old very obese patient with high blood pressure, who has a disabled left arm due to a previous stroke. She is to stay in bed except for commode privileges for bowel movement only. Before starting morning care, Mrs. M. needs the bedpan for urination. She has difficulty lifting her buttocks. To put Mrs. M on the bedpan, the first step is to:

   a. lift the hips.
   b. place the pan against the buttocks.
   c. roll the resident to one side.
   d. roll the resident on the pan.

3. A partial bath includes washing all of the following except:

   a. face and hands.
   b. back.
   c. legs.
   d. genitals.

4. An important observation you made during the bath that indicates a patient's skin is ready to form a decubitus over a bony prominence is:

   a. redness that disappeared with light massage.
   b. dry, flaky skin.
   c. redness that did not disappear with light massage.
   d. a small break in the skin with a watery discharge.

5. Female perineal care is correctly accomplished by washing and then drying the area from the:

   a. rectum to the urinary opening.
   b. vagina to the recturm, to the urinary opening.
   c. vagina to the urinary opening.
   d. urinary opening to the rectum.

6. A resident's finger nails and toe nails need cleaning and cutting. This can be done more easily and safely:

   a. before the bed bath.
   b. after soaking them in warm, soapy water.
   c. with a metal file.
   d. by a family member.

7. To prevent a decubitus ulcer the nursing assistant will:

   a. turn the resident on his/her side.
   b. apply medicated lotion to the bony prominence.
   c. bathe any reddened area of skin frequently.
   d. change position of the resident every two hours.

8. A basic principle of bandaging relates to how it is applied. Which statement is correct?

   a. wrapped toward the heart
   b. wrapped away from the heart

9. The doctor may order dry to moist application of heat to a resident. Heat is used to:

   a. speed up the healing process.
   b. prevent swelling.
   c. contract the blood vessels.
   d. all of the above.

10. Which of the following is/are the nursing assistant's responsibility regarding the resident with an indwelling catheter:

    a. check to see if urine is draining.
    b. wash the genital area around the catheter carefully when bathing.
    c. never pull on the catheter or raise the bag above the bladder.
    d. all of the above.

11. Special needs of elderly include all but one of the following:

    a. frequent baths with lots of soap.
    b. special diets to provide adequate protein.
    c. shaving or cutting of coarse facial hair.
    d. motion or exercise of some sort.

12. To maintain good balance when carrying a dinner tray, you should keep the tray:

    a. on your shoulder.
    b. at arms length.
    c. about waist level.
    d. about chest height.

13. When the nurse serves a tray to a patient, it is essential that s/he:

    a. lower the head of the bed.
    b. close the curtains for privacy.
    c. checks the patient's identification band with the diet card on the tray.
    d. ask the patient if s/he had a bowel movement today.

14. A hemiplegic patient should get out of bed:

    a. toward the affected side
    b. toward the unaffected side.
    c. without assistance.
    d. with the use of a Hoyer lift.

15. Before helping a patient into or out of a wheelchair, which of these actions are necessary?

    a. have brakes unlocked, footpieces down
    b. have brakes locked, footpieces down
    c. have brakes unlocked, footpieces up
    d. have brakes locked, footpieces up

16. Some things to remember in exercising a resident are:

    a. support the joint being exercised.
    b. exercise any joint you feel like exercising first.
    c. stop if the resident complains of pain.
    d. a & c only.

17. When patients are incontinent, it is sometimes possible to train them. One way the nurse aide can help during the first stages is by:

    a. trying to make the patient feel ashamed
    b. cleaning the patient without talking to him.
    c. telling the patient not to drink a lot of water.
    d. noticing at what time of the day the patient voids or has a bowel movement.

BASIC NURSING

18. A rectal temperature measures _____ degree _____ than a oral temp.

    a. one degree higher
    b. two degrees higher
    c. one degree lower
    d. two degrees lower

19. How long should you leave an axillary thermometer in place?

    a. 3 minutes
    b. 10 minutes
    c. 1 minutes
    d. 15 minutes

20. To accurately assess or take a pulse, you should make observations about the:

    1. turbulence.
    2. rhythm.
    3. volume.
    4. rate.
    5. condition of arterial wall.

        a. 1 and 4
        b. 2 and 3
        c. 2, 3 and 4
        d. 2, 3, 4 and 5

21. The usual range for the pulse rate of a healthy adult is:

    a. 40-80 beats per minute.
    b. 50-120 beats per minute.
    c. 60-100 beats per minute.
    d. 60-72 beats per minute.

22. A pulse which is markedly abnormal in rhythm and volume should be assessed for which one of the following periods of time?

    a. 30 seconds and multiplied by 2
    b. 15 seconds and multiplied by 4
    c. 60 seconds

23. Of the following pulse rates, which should you report to the nurse as being outside the normal range for an adult?

    1. 96
    2. 50
    3. 72
    4. 140

        a. 1, 3
        b. 1, 2, 4
        c. 2, 4

24. Which of the following respiratory rates is within the usual range of a normal adult?

    a. 8 respirations per minute
    b. 16 respirations per minute
    c. 32 respirations per minute
    d. 40 respirations per minute

25. You are about to take Mrs. Brown's oral temperature when it is observed that she has just finished an iced drink. Which of these actions is indicated?

    a. taking Mrs. Brown's temperature rectally
    b. having Mrs. Brown drink a warm beverage and then take her temperature
    c. taking Mrs. Brown's temperature after a few minutes
    d. taking Mrs. Brown's temperature and recording it

26. The highest pressure of blood which is exerted against the arterial wall is called:

    a. systolic blood pressure.
    b. vasodilation.
    c. diastolic blood pressure.
    d. vasoconstriction.

27. The lowest pressure exerted against the arterial walls is called:

    a. systolic blood pressure.
    b. vasodilation.
    c. diastolic blood pressure.
    d. vasoconstriction.

28. A blood pressure of 160/100:

    a. is normal.
    b. has a systolic deviation.
    c. has a diastolic deviation.
    d. has a systolic and diastolic deviation.

29. A blood pressure of 120/100:

    a. is normal.
    b. has a systolic deviation.
    c. has a diastolic deviation.
    d. has a systolic and diastolic deviation.

30. You are assigned Mrs. T who is on intake and output. For supper she had one small hamburger, one baked potato, one serving of carrots, dish of jello, glass of milk, fruit juice and cup of coffee. She ate well, eating 1/2 of her jello, 3/4 of her milk, all her fruit juice and coffee. In this institution the intake scale is as follows: jello 120cc, milk carton 240cc, fruit juice glass 120cc, and coffee cup 150cc. What intake would you record?

    a. 210cc
    b. 350cc
    c. 510cc
    d. 600cc

31. The dying patient starts to talk about death. The nursing assistant should:

    a. talk about the weather.
    b. listen to the patient.
    c. leave the room.
    d. tell the patient everything is going to be "all right".

32. When a patient is dying there may not be very much the nursing assistant can do to help the family. But, one important thing the aid can do for the family members is to:

    a. tell them about the details of the patient's condition.
    b. ask them questions about the patient and how the illness started.
    c. recognize that they may have a right to be with the patient and not make them feel that they are in the way.
    d. ask "how many more relatives will be coming?"

33. When giving an S.S. enema, the rectal tube is inserted:

    a. 2-4 inches.
    b. 6-8 inches.
    c. 8-10 inches.
    d. until resistance is felt.

34. You are assigned Mrs. L's TPR. Her oral temperature is 99°F, pulse, 50, with beats evenly spaced and strong, respirations 30 without effort. Which of the following statements is true regarding Mrs. L's vital signs?

    a. She has a low grade fever. She has tachycardia. Respiratory rate is above normal.
    b. Her temperature and respiration are within normal rate. She has bradycardia.
    c. Her temperature is within normal range. Pulse is irregular and slow. Respiratory rate is above normal.
    d. Her temperature is within normal range. She had bradycardia. Her respiratory rate is above normal.

35. Residents with respiratory problems will usually be positioned in:

    a. semi-fowlers position.
    b. supine position.
    c. lateral position.
    d. dorsal recumbent position.

36. In which of the following situations would an oral temperature not be taken?

    a. after oral surgery
    b. 2 years old
    c. combative
    d. all of the above

COMMUNICATION

37. Fundamentals of oral communication include:

    a. speaker, listener, message and feedback.
    b. the speaker speaking very loudly.
    c. using hand and body movements.
    d. writing the communication.

38. The nursing assistant can improve communications with a hard of hearing resident by:

    a. speaking very loudly.
    b. speaking slowly and clearly.
    c. gesturing with the hands.
    d. being as pleasant and brief as possible.

39. Methods used to communicate with people, other than words or in writing are:

    a. writing the communication.
    b. hand and body gestures.
    c. speaking very loudly.
    d. tone of voice.

40. Good communication with residents include all the following except:

    a. speak slowly, clearly and in a pleasant tone.
    b. respect resident's moods, sometimes silence is bliss.
    c. show an interest in what the resident is saying by your mannerisms.
    d. use medical terms so your explanation will be accurate.

PATIENT'S RIGHTS

41. A nursing assistant needs to be a good listener. Which of the following indicates this quality?

    a. interrupt when resident is talking.
    b. plan what you're going to do next, but appear to listen
    c. maintain eye contact and give him/her full attention
    d. help resident when he can't think of a word in a repeated story

42. You enter Mary Brown's room just in time to duck a water pitcher that's been hurled toward the door. You should:

    a. get help so you can hold Mrs. Brown down since she's out of control.
    b. say, "Mrs. Brown, I haven't done anything to deserve that, why did you throw the pitcher at me?"
    c. insist that Mrs. Brown apologize for her nasty temper.
    d. quietly pick up the pitcher as you say, "Would you like to tell me what's happening with you? Maybe I can help."

43. Residents are protected from illegal acts by all state and federal laws. Which of the following is not an illegal act?

    a. a nursing assistant applies a restraint without a doctor's order
    b. striking a resident who struck you
    c. opening a resident's mail and reading it with his permission
    d. not permitting a resident to use the telephone

44. Residents may mention religious beliefs with which the nursing assistant doesn't agree. Which of the following would be the best guide for the nursing assistant?

    a. It is best to pretend to have the same beliefs that the resident expresses.
    b. The nursing assistant has a right to explain his/her own beliefs in detail to the resident.
    c. When a person is sick, it is a good time to teach him true religion.
    d. Each person has a right to his own beliefs, but should respect another's beliefs which might differ.

45. Confidentiality is a necessity for all health workers to remember. This means a nursing assistant cannot talk about a resident's diagnosis or treatment to:

    a. nurse in charge.
    b. coworkers caring for same resident.
    c. doctor.
    d. roommate of resident.

46. The chart is a legal confidential document that belongs to the:

    a. resident.
    b. doctor.
    c. institution.
    d. court.

47. Failure to use curtains, bath blankets or other drapes while performing a nursing procedure is considered to be:

    a. carelessness in following the steps of the procedure.
    b. an invasion of the resident's privacy.
    c. excusable if the nursing assistant is in a hurry.
    d. unimportant as long as the resident does not complain.

SOCIAL NEEDS

48. The best nursing care of the confused, disoriented resident includes:

    a. going along with the confusion in a passive manner.
    b. reality orientation.
    c. making jokes about the resident's statements.
    d. giving directions and expecting them to be followed.

49. Another nursing assistant overhears you telling a resident the date and time and says, "Why bother, these people never improve; they're just old." The best response would be:

    a. "You're right, I guess I'm being silly."
    b. "You may have a point, but it doesn't hurt to try, does it?"
    c. "Disorientation can be cured if reality orientation is used."
    d. "It's true that some won't improve, but some do. I feel better knowing that I made an effort."

50. A resident had a CVA (Cerebral Vascular Accident) and was paralyzed on the left side. The nursing assistant can help this resident by:

    a. doing everything for her.
    b. encouraging her to do for herself.
    c. telling her she will get better.
    d. giving her lots of instruction.

51. In caring for the geriatric resident it is important to maintain his self esteem and respect. One way to do this is to:

    a. do everything for him in an organized manner.
    b. make all decisions and proceed with your care plan.
    c. let the resident do all he can of his care.
    d. leave him in his pajamas and robe.

52. You can make your residents feel secure by:

    a. providing a safe environment.
    b. helping residents feel comfortable in nursing home.
    c. helping residents trust you and the care you provide.
    d. all of the above.

53. An elderly resident sits hugging a doll as she rocks. This probably illustrates an unmet need for:

    a. food.
    b. love.
    c. respect.
    d. health.

54. Social needs relate to the need for approval and acceptance. You can help residents meet their social needs when you:

    a. praise the resident for accomplishments.
    b. address the resident by endearing names such as Sweetie or Pops.
    c. give the resident 6-8 glasses of water per day.
    d. none of the above.

55. The nursing assistant can help a new resident relax and feel at home in the nursing home if he/she will:

    a. immediately introduce the resident to five or six other residents.
    b. take time to explain the routine, and show the resident the call light and bathroom, etc.
    c. ignore the resident's worries as all new residents are upset.
    d. give the resident a nice tub bath to promote relaxation.

56. When a patient is admitted to the hospital, he/she may be fearful and anxious. As a nursing assistant you can help to establish his/her confidence and put him/her at ease by:

    1. exploring use of hospital equipment such as the call signal, television, telephone, etc.
    2. exploring hospital policies, such as meal times, visiting hours, etc.
    3. explaining procedures before performing them.
    4. discussing the operation with him/her and answering his/her questions.

        a. 1, 2, 4
        b. 1, 3, 4
        c. 1, 2, 3
        d. all of the above

SAFETY AND EQUIPMENT

True or False: darken A for true and B for false on questions 57-64.

57. Electrical appliances like a razor may be used when oxygen is in use.

58. You should always make sure the resident can reach his signal cord before you leave his unit.

59. The side rails are usually raised and the bed raised when the resident is in bed.

60. Falls are the most common accident in the nursing home.

61. Cyanosis and dyspnea are signs which indicate a threat to the patient's health.

62. Any broken or hazardous equipment should be reported immediately to the nurse by the nursing assistant.

63. Restraints should be checked once on every shift.

64. Your resident fainted while in the tub. Your best action is to let the water out and turn on the call signal.

65. If a fire breaks out in a patient room, your first responsibility is:

   a. clear the hallways.
   b. notify the head nurse.
   c. the safety of the patient.
   d. close all doors.

66. A clean sheet falls to the floor. The best action for you to take would be to:

   a. obtain a clean one.
   b. use it since it didn't get dirty.
   c. shake it to brush off dirt that may adhere to the surface.
   d. use it to cover the linen cart since it shouldn't be used for a patient.

67. Which of the following actions is a major safety precaution when making an occupied bed?

   a. have bed in low position and locked
   b. assist resident in moving on to clean linen by scooting buttocks over the hump first
   c. make complete bed on one side before going to other side
   d. raise side rail on side to which resident is turned

68. For which of the following incidents must you make an incident report?

   a. a patient falling out of bed
   b. theft of a patient's purse
   c. a visitor falling in the hall
   d. sticking your finger with a pin
   e. all of the above

69. In the nursing home you find a resident on the floor in the bathroom. She states, "I fell, help me up." You should:

   a. leave the room and summon more help.
   b. bring a chair to the bathroom.
   c. ring the emergency call signal and stay with the resident.
   d. get the Hoyer lift.

70. Cross infections in health facilities are most commonly spread by health workers and are caused by:

   a. mixing up clean and dirty areas.
   b. unwashed hands.
   c. sneezes and coughs.
   d. all of the above.

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Student's Name ____________________

INTRODUCTION TO NURSING

Provider of Care Skills Check List	S	U	Comments
Handwashing			
Bedmaking			
Bathing			
Chair shower			
Bed Bath			
Partial			
Back Massage			
Hair, Nail, Footcare			
Oral hygiene including dentures			
Feeding			
Body mechanics			
Transfers			
Hoyer			
Elimination			
Urinal			
Bedpan			
Commode			
TEDs			
Urine specimen			
Condom catheter			
Enemas			
fleets			
soap suds			
Vital Signs			

Nursing Fundamentals I
Check List
Page Two

Provider of Care Skills Check List	S	U	Comments
Rom active			
passive			
Catheter male			
female			
irrigation			
specimen			
Gloving			
Dressing change			
Warm moist packs			
Isolation			
OTHERS:			

NFI/SkillsChecklist
mo/10/87

EXHIBIT E

CHIPPEWA VALLEY TECHNICAL COLLEGE
NURSING DIVISION

STUDY GUIDE

FOR

Demonstration of Proficiency by Licensed Practical Nurses

IN

510-110	Introduction to Nursing	3 credits
510-101	Nursing Skills I	1 credit
510-114	Nursing Skills II	1 credit
	Total Credits =	5

HOW?

Achieve a score of 78% or above on a written examination.
Demonstrate mastery of nursing skills in simulated laboratory situations.

WHERE?

Chippewa Valley Technical College, Phillips Building
Nursing Skills Laboratory (P204)

WHEN?

The semester prior to your scheduled enrollment in the first 510 nursing course. Make appointment by calling (715) 833-6396.

HOW MUCH TIME SHOULD I ALLOW?

Written Examination: 2 hours 30 minutes
Mastery Skill Demonstration: 1 hour

WHAT IS THE COST?

$50.00: Complete the attached form and pay at the Cashier's Office.

WHAT IF I FAIL THE WRITTEN EXAMINATION?

You will need to apply for admission to the generic track of the ADN program. You will take all three of the courses listed on the first page of this study guide.

WHAT IF I FAIL THE MASTERY SKILL DEMONSTRATION?

You will need to enroll in Nursing Skills I and Nursing Skills II.

MAY I SCHEDULE BOTH THE WRITTEN EXAMINATION AND THE MASTERY SKILL EXAMINATION ON THE SAME DAY?

Yes, but you need to allow for scoring of the written examination before you complete the mastery skill demonstration. You will **not** be permitted to do the mastery skill examination if you scored below 78% on the written examination.

WHERE CAN I FIND MORE INFORMATION?

Reference books, the course syllabi, course outlines, and evaluation instruments are located in the Nursing Laboratory (P204).

STUDY HINTS

WRITTEN EXAMINATION

Objectives:

1. Identify behaviors that promote successful learning.
2. Identify behaviors that promote positive relationships.
3. Identify responsible and ethical behavior of members of the nursing team.
4. Identify effective verbal and non-verbal communications skills.
5. Identify behaviors that are supportive to patients and their families.
6. Provide a safe patient care environment.
7. Use nursing care measures that meet the unique needs of individual patients.
8. Protect the rights of the patient.
9. Protect the health of self, the patient and co-workers while providing patient care.
10. Apply the principles of written communication when reporting and recording information.
11. Use appropriate terminology when reporting and recording information.
12. Apply knowledge and skills from past and current educational experiences to new situations.
13. Move progressively from application of concepts to one's own experiences, to more abstract applications of concepts to the experiences of others.
14. Demonstrate culture/ethnic/age sensitive communication and behavior skills that are supportive to patients and their families.
15. Apply the concept of caring as the primary purpose of nursing, and the concept of neglecting as an impediment to that purpose.

Review the following topics.

SECTION I

Personal Care Skills
Vital Signs
Intake and Output
Death and Dying
Communication
Patient's Rights
Social Needs
Safety and Equipment

SECTION II

Growth and Development
Spiritual/Social Cultural Needs
Nutritional Needs
Self Concept
Communication
Reporting and Recording
Legal/Ethical Issues
Sleep and Rest
Asepsis/Sterile Technique
Infection
Grief and Loss
Intake and Output
Bowel and Bladder Elimination

MASTERY SKILL EXAMINATION

You will need to bring a partner to play the role of a patient in some portions of the mastery skill examination. In order to be successful on this motor skill performance, the student may not exceed a maximum of six (6) prompts while performing all of the steps. **NOTE:** Performance areas identified by an asterisk (*) as critical must be completed without prompts.

I. **Apical Pulse Objectives** (7 min.)

1. Prepare the environment for the procedure.
2. Demonstrate communication skills.
3. Demonstrate good body mechanics.
4. Accurately locate and count pulse for appropriate length of time.
5. Record the pulse accurately.
6. Describe the pulse rate rhythm, volume, and any variations in the pulse.

II. **Catheterization Objectives** (15 min.)

A prepackaged catheterization kit and a female manniquin will be provided at the site. The student is to demonstrate catheterization technique according to these objectives:

1. Prepare the patient and the environment for the procedure.
2. Catheterize the mannequin using a straight catheter.
3. Maintain sterility throughout the procedure.
4. Demonstrate communication skills.
5. Demonstrate good body mechanics and alignment.
6. Record observations accurately.
7. Restore the environment to its prior condition.
8. Maintain a safe environment.

III. **Changing a Dry Sterile Dressing Objectives** (15 min.)

Dressings and a manniquin will be provided at the site. The student is to demonstrate surgical aseptic technique in cleaning and dressing a non-draining wound.

1. Prepare the patient and the environment for the procedure.
2. Select appropriate sterile dressings and equipment to clean and redress non-draining wound.
3. Demonstrate communication skills.
4. Demonstrate good body mechanics.
5. Position client for safety and comfort.
6. Maintain sterility throughout the procedure. Use appropriate technique to clean a wound.
7. Record observations accurately.
8. Restore the environment to its prior condition.
9. Dispose of soiled dressing and equipment appropriately.

IV. **Administration of an Injection Objectives** (15 min.)

Four situations are identified below; the student is given one situation for which s/he prepares the injection, identifies the injection site on the mannequin and administers the injection.

1. Maintain sterility throughout procedure.
2. Select appropriate syringe and needle.
3. Accurately prepare medication.
4. Position client for safety, comfort, and visualization of site.
5. Identify site accurately.
6. Demonstrate communication skills.
7. Maintain a safe environment.
8. Use proper body mechanics.

Situation 1: Prepare and give 1 cc sterile normal saline or sterile water in the ventrogluteal site.

Situation 2: Prepare and give 1 cc sterile normal saline or sterile water in the dorsigluteal site.

Situation 3: Prepare and give 1 cc sterile normal saline or sterile water in the vastus lateralis.

Situation 4: Prepare and give 1 cc sterile normal saline or sterile water in the mid-deltoid site.

REFERENCES

The following references will be helpful in preparing for the written and motor skills challenge examinations. Students are expected to select and study the material to facilitate an understanding of the content and motor skills. These references are available in the Nursing Laboratory (P204).

Kozier, B., Erb, G. Techniques in Clinical Nursing Third Ed., Addison-Wesley, 1989.

Autotutorial Materials: Lippincott Learning System (MED 82-203)

Kozier, B., Erb, G. and Buffalino, P. Introduction to Nursing, Addison-Wesley, 1989.

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StudyGui.F89

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING
Challenge Exam

1. A basic principle of bandaging relates to how it is applied. Which statement is correct?

    a. wrapped toward the heart
    b. wrapped away from the heart
    c. direction is only significant in cardiac patients
    d. either way is okay if the bandaging is firm

2. The doctor may order dry to moist application of heat to a resident. Heat is used to:

    a. speed up the healing process.
    b. prevent swelling.
    c. contract the blood vessels.
    d. all of the above.

3. A hemiplegic patient should get out of bed:

    a. toward the affected side
    b. toward the unaffected side.
    c. without assistance.
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    c. one degree lower
    d. two degrees lower

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    b. 10 minutes
    c. 1 minutes
    d. 15 minutes

6. To accurately assess or take a pulse, you should make observations about the:

    1. turbulence.
    2. rhythm.
    3. volume.
    4. rate.
    5. condition of arterial wall.

        a. 1 and 4
        b. 2 and 3
        c. 2, 3, and 4
        d. 2, 3, 4 and 5

7. The usual range for the pulse rate of a healthy adult is:

   a. 40-80 beats per minute.
   b. 50-120 beats per minute.
   c. 60-100 beats per minute.
   d. 60-72 beats per minute.

8. A pulse which is markedly abnormal in rhythm and volume should be assessed for which one of the following periods of time?

   a. 30 seconds and multiplied by 2
   b. 15 seconds and multiplied by 4
   c. 60 seconds.

9. Of the following pulse rates, which should you report to the nurse as being outside the normal range for an adult?

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   2. 50
   3. 72
   4. 140

      a. 1, 3
      b. 1, 2, 4
      c. 2, 4

10. Which of the following respiratory rates is within the usual range of a normal adult?

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    b. 16 respirations per minute
    c. 32 respirations per minute
    d. 40 respirations per minute

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    b. has a systolic deviation.
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    d. has a systolic and diastolic deviation.

15. A blood pressure of 120/100:

    a. is normal.
    b. has a systolic deviation.
    c. has a diastolic deviation.
    d. has a systolic and diastolic deviation.

16. You are assigned Mrs. T who is on intake and output. For supper she had one small hamburger, one baked potato, one serving of carrots, dish of jello, glass of milk, fruit juice and cup of coffee. She ate well, eating 1/2 of her jello, 3/4 of her milk, all her fruit juice and coffee. In this institution the intake scale is as follows: jello 120cc, milk carton 240cc, fruit juice glass 120cc, and coffee cup 150cc. What intake would you record?

    a. 210cc
    b. 350cc
    c. 510cc
    d. 600cc

17. You are assigned Mrs. L's TPR. Her oral temperature is 99°F, pulse, 50, with beats evenly spaced and strong, respirations 30 without effort. Which of the following statements is true regarding Mrs. L's vital signs?

    a. She has a low grade fever. She has tachycardia. Respiratory rate is above normal.
    b. Her temperature and respiration are within normal rate. She has bradycardia.
    c. Her temperature is within normal range. Pulse is irregular and slow. Respiratory rate is above normal.
    d. Her temperature is within normal range. She had bradycardia. Her respiratory rate is above normal.

18. Residents with respiratory problems will usually be positioned in:

    a. semi-fowlers position.
    b. supine position.
    c. lateral position.
    d. dorsal recumbent position.

19. In which of the following situations would an oral temperature not be taken?

    a. after oral surgery
    b. 2 years old
    c. combative
    d. all of the above

20. A resident had a CVA (cerebral vascular accident) and was paralyzed on the left side. The nursing assistant can help this resident by:

    a. doing everything for her.
    b. encouraging her to do for herself.
    c. telling her she will get better.
    d. giving her lots of instruction.

21. If a fire breaks out in a patient room, your first responsibility is:

    a. clear the hallways.
    b. notify the head nurse.
    c. the safety of the patient.
    d. close all doors.

22. In the nursing home you find a resident on the floor in the bathroom. She states, "I fell, help me up." You should:

    a. leave the room and summon more help.
    b. bring a chair to the bathroom.
    c. ring the emergency call signal and stay with the resident.
    d. get the Hoyer lift.

23. Maslow's theory of human development is based on:

    a. human needs.
    b. psychosexual drives
    c. cognitive process
    d. forces of socialization

24. A myth about older adults is that they:

    a. are physically active.
    b. possess a wealth of experiences.
    c. have decreased learning ability.
    d. continue to be interested in sex.

25. Which one of the following interventions would best facilitate reality orientation for the older adult client?

    a. make decisions for her/him concerning health practices
    b. ignore rambling conversation and unrealistic talk
    c. let her/him know when s/he is confused or uses incorrect words
    d. include information such as time, place, and name in conversation

26. A technique to help the older adult reconcile conflicts and disappointments is:

    a. reminiscence.
    b. socialization.
    c. recreation therapy.
    d. attitudinal therapy.

27. Mr. Smith, 86-years-old, is in an extended care facility. Because Mr. Smith's nutritional needs have changed since middle adulthood, his diet should have:

    a. decrease calories.
    b. decrease minerals.
    c. decrease vitamins.
    d. decrease proteins.

28. Which of the following goals would be appropriate for a client dealing with spiritual distress related to separation from religious ties? The client will:

    a. recognize that s/he has limited control over spiritual issues.
    b. accept that it is difficult to meet religious obligations when ill.
    c. acknowledge that other people have similar concerns about spirituality.
    d. verbalize concerns about spiritual needs and identify ways to meet them.

29. When planning care for a client experiencing spiritual distress, the nurse should:

    a. support and enhance the client's belief system.
    b. delegate this aspect of care to the clergy.
    c. acknowledge that her/his expertise is limited in this area.
    d. determine her own worthiness before addressing these issues.

30. Which one of the following patients is most likely to suffer from sensory deprivation?

    a. a patient being cared for in an intensive care unit.
    b. a patient who must use a wheelchair to get about.
    c. a patient convalescing after back surgery.
    d. a patient sharing a room with another patient of the same age.

31. Self-concept may be best described as:

    a. an individual's perception of his physical appearance.
    b. an incorporation of body image, self-esteem, role, and identity.
    c. a composite of the functional self, idealized self, and real self.
    d. a subjective opinion of how self is viewed by significant others.

32. An individual who is ambivalent about his/her role generally:

    a. has low self-esteem.
    b. is unable to arrive at a decision.
    c. is unclear about what is expected.
    d. has failed to merge the ideal and the real self.

33. To help a client with an altered self-concept, it is important that the nurse:

    a. acknowledge that it is possible for his/her interventions to have an impact on the client.
    b. analyze the underlying dynamics and reasons for the problem.
    c. inform the client that his/her opinion of self needs to be improved and changed.
    d. recognize that dealing with this problem is outside a nurse's area of expertise.

34. After radical surgery, an individual denies that his/her physical appearance has changed. Which of the following nursing interventions would be appropriate to help him/her deal with his/her altered body image?

    a. encourage him/her to express feelings about his/her illness and treatment
    b. pretend that his/her appearance is similar to what it was prior to the operation
    c. arrange for the clergy to visit him/her and discuss the situation
    d. inform him/her that s/he is still the same person that s/he was prior to surgery

35. In order for the nurse to help a client deal with issues related to sexual health, it is important that the nurse know that sexuality is best defined as:

    a. knowing oneself as a male or female.
    b. a heterosexual relationship with the opposite sex.
    c. the biological aspects of male-female relationships.
    d. the gender that the individual inherits from parents.

36. When providing care to clients with varied cultural backgrounds, it is imperative for the nurse to recognize that:

    a. cultural considerations must be put aside if basic needs are in jeopardy.
    b. making generalizations about the behavior of a particular group may be inaccurate.
    c. current health standards should determine the acceptability of cultural practices.
    d. similar reactions to stress will occur when individuals have the same cultural background.

37. A negative effect of ethnocentrism occurs in the nurse-client relationship when the nurse:

    a. views the client on the basis of his/her own cultural standards.
    b. recognizes the effect of cultural heritage on client's reactions.
    c. becomes sensitive to manifestations of racism in the institutional environment.
    d. uses value clarification exercise to determine how she differs from the client.

38. When communicating with a client whose native language is not English, the nurse should:

    a. try to use his/her own dialect and colloquialisms.
    b. let him/her know you have friends who speak the same language.
    c. avoid letting him/her know that you are having difficulty understanding.
    d. explain nursing care and medical procedures in simple everyday words.

39. In order to avoid cultural conflicts, the nurse should:

    a. let the client know that s/he is receiving quality care.
    b. provide the client health information about the dominant group.
    c. ask the client his/her expectations about nursing care and procedures.
    d. avoid nursing interventions that might cause the client embarrassment.

40. To be effective in meeting various ethnic needs, the nurse should:

    a. treat all clients alike.
    b. be aware of client's cultural differences.
    c. act like s/he is comfortable with the client's behavior.
    d. avoid asking questions about the client's cultural background.

41. For communication to be effective:

    a. there must be verbal interaction.
    b. a person's perceptions must be changed.
    c. the message must be similar for the speaker and the receiver.
    d. all role boundaries are concealed.

42. While checking Mr. Sam's blood pressure, the nurse asks, "How are you feeling?" He says, "That feels tight on my arm." This feedback most likely tells the nurse:

    a. Mr. Sam is disoriented.
    b. the meaning of her message was not received.
    c. her facial expression conveyed a different message.
    d. Mr. Sam did not want to talk about how he was feeling.

43. The use of touch in the nurse-client relationship:

    a. should be used sparingly.
    b. is inappropriate except for physical care activities.
    c. can be a therapeutic tool.
    d. has only sexual implications.

44. Establishment of trust between the nurse and client allows:

    a. the nurse to meet personal goals.
    b. the client to express thoughts more openly.
    c. the nurse to maintain a position of dominance.
    d. communication to become less formal.

45. Which of the following statements are true regarding nonverbal communication?

    1. The majority of communication is nonverbal.
    2. Nonverbal communication is more consciously controlled than verbal behavior.
    3. The nurse needs to remember that his/her own nonverbal behavior is under constant scrutiny by the patient.
    4. Nonverbal behavior either reinforces or contradicts what is said verbally.

        a. 1, 2, 3
        b. 1, 2, 4
        c. 1, 3, 4
        d. 2, 3, 4

46. Listening, to be effective, requires which of the following?

    1. observe body gestures
    2. be receptive and attentive
    3. listen to the speaker
    4. use feedback

        a. 1, 2, 3
        b. 1, 2, 4
        c. 1, 3, 4
        d. 1, 2, 3, 4

47. The use of stereotypical and trite comments when a nurse communicates with a patient most often conveys the message that the nurse is:

    a. lacking in humor.
    b. angry with the patient.
    c. uninterested in conversation.
    d. feeling hostile toward the patient.

48. Mrs. Jones, 66, has been hospitalized with a diagnosis of Myocardial Infarction. His wife visits him every day and he speaks with her on the phone frequently. One day after talking to his wife on the phone Mr. Jones says to the nurse, "I wish I could see my wife more often." Which of these responses by the nurse would be most appropriate?

   a. "Some patients have even fewer visits from their families."
   b. "It's hard for you to be separated from your wife."
   c. "But your wife has all the responsibility of caring for the children."
   d. I'll speak to your wife about your concern."

49. Nurses collect data through:

   1. taking a history from client or family
   2. inspection
   3. palpation
   4. auscultation

      a. 1, 2, 3
      b. 1, 3, 4
      c. 2, 3, 4
      d. all of the above

50. Incident reports are:

   1. for situations involving patient, visitors or employees.
   2. filled out by a person present at time of incident.
   3. sometimes countersigned by the team leader or head nurse.
   4. in nurse's own words and handwriting.

   a. 1 only
   b. 1 and 3 only
   c. 1, 2, 3 only
   d. all of the above

51. If an error is made while recording, the nurse should:

   a. erase or scratch it out.
   b. obtain a new nurse's note and rewrite the entries.
   c. leave a blank space in the note.
   d. draw a single line through the error and initial it.

52. A nurse observes an incident of incompetence in the nursing practice of a co-worker. Which of these actions should the nurse take first?

   a. discuss the situation with the co-worker involved
   b. report the observation to the director of nursing
   c. continue to observe the co-worker
   d. share the information about the incident with the staff of the next shift

53. A confused patient who fell out of bed because side rails were not used is an example of which type of liability?

    a. a felony
    b. assault
    c. battery
    d. negligence

54. Good Samaritan laws encourage health care professionals to give assistance in accidents because they:

    a. supply funds for first aid training.
    b. limit legal liability in emergency situations.
    c. establish standard treatments for emergency aid.
    d. identify nurse's role in emergency situations.

55. Your neighbor asks you for information regarding a hospitalized friend's condition. Your reply should be influenced by:

    a. the patient's right to confidentiality.
    b. your lack of knowledge of the treatment plan.
    c. the neighbor's genuine interest in his/her friend.
    d. your fear of legal involvement in the case.

56. If a health worker fails to knock before entering a patient's room when the door is closed, the health worker shows lack of respect for:

    a. controlling noise.
    b. other health workers' working space.
    c. the patient's need for rest.
    d. the patient's privacy.

57. The usual reason for the doctor's restraint order is:

    a. to keep the patient quiet.
    b. to relieve the nurse of extra work.
    c. to keep the patient in his/her room.
    d. to protect the patient.

58. What action is appropriate when restraining a patient in bed?

    a. always position the person on his/her back
    b. check the patient's skin once a day
    c. attach the restraint to the part of the bed frame that moves with the patient
    d. keep the bed flat

59. A patient is placed in restraints because he said he wished to leave the hospital. This is an example of:

    a. fraud.
    b. negligence.
    c. false imprisonment.
    d. invasion of privacy.

60. A nurse said that she was a registered nurse while awaiting results of the licensing exam. This is an example of:

    a. fraud.
    b. negligence.
    c. false imprisonment.
    d. invasion of privacy.

61. A nurse did not question a physician's order and gave an improper dosage of a drug to a patient. This is an example of:

    a. fraud.
    b. negligence.
    c. false imprisonment.
    d. invasion of privacy.

62. Which one of the following terms is generally used to describe professional negligence?

    a. libel
    b. liability
    c. omission
    d. malpractice

63. Nurses who make false, oral statements about patients that subject patients to ridicule or contempt run the risk of being sued for:

    a. libel
    b. battery
    c. slander
    d. invasion of privacy

64. Miss Nelson, RN, tells her friends that she is caring for Sam Jones, an AIDS victim. Mr. Jones is the president of a large business organization. Miss Nelson could be charged with:

    a. libel
    b. battery
    c. invasion of privacy
    d. felony

65. The primary purpose for the nurse practice act is to:

    a. upgrade the profession.
    b. protect the public welfare.
    c. provide safe environments for patients.
    d. accredit educational programs in nursing.

66. Lack of sleep and rest can result in:

    a. a decrease in daily activity participation.
    b. an increase in irritability.
    c. a decrease in the ability to concentrate.
    d. all of the above.

67. Mr. Blue is admitted to the hospital due to sleep difficulties. Which of the following is INCORRECT concerning the stages of sleep?

    a. The adult routine sleep pattern begins with a presleep period during which the person becomes increasingly drowsy.
    b. Once asleep the person passes through four stages of REM sleep and a period of nonREM sleep.
    c. NonREM stage I is the lightest level of sleep, lasting only a few minutes.
    d. NonREM stage III is the initial stage of deep sleep.

68. Which of the following statements most accurately describes sleep patterns commonly observed in the elderly?

    a. The elderly seldom dream.
    b. The elderly require more sleep than middle-age adults.
    c. The elderly tend to prefer to sleep late in the morning.
    d. The elderly take longer to go to sleep and tend to waken earlier.

69. Management of external environment is often necessary to promote rest. Nursing activities that promote rest include:

    1. controlling or eliminating noise when possible.
    2. giving a blanket to the patient who is cold.
    3. spacing nursing activities for the benefit of the patient rather than the convenience of the nurse.
    4. keeping the patient out of bed as much as possible so s/he will sleep all night.

        a. 1, 2, 3
        b. 1, 2, 4
        c. 3, 4
        d. all of the above

70. Which of the following principles of asepsis should the nurse follow when changing bed linens?

    a. keep soiled linen away from the nurse's uniform
    b. never fan linen so as to avoid air currents that can spread microorganisms
    c. if clean linen touches the floor, it should be discarded
    d. all of the above

71. Which of the following best describes a nosocomial infection?

    a. results from the delivery of health services in a health care facility
    b. results from an extended infection to the urinary tract
    c. involves an incubation period of 3 to 4 weeks before detected
    d. symptoms are the same as for the common cold

72. The best example of medical asepsis would be:

    a. hand washing.
    b. use of sterile instruments.
    c use of proper gloving technique.
    d. autoclaving.

73. The therapeutic application of heat at the site of an infection will:

    a. promote blood flow to the site.
    b. decrease swelling.
    c. decrease local redness.
    d. decrease purulent drainage.

74. Which of the following is not a symptom of a localized infection?

    a. redness
    b. edema
    c. tenderness
    d. fever

75. Which best describes medical asepsis?

    a. prevents spread of pathogens.
    b. sterile technique.
    c. destroys all pathogens in an area.
    d. absence of all microorganisms in an area.

76. The primary purpose of isolation technique is to prevent pathogens from:

    a. touching the nurse.
    b. spreading from the area of source.
    c. reaching the patient.
    d. contaminating the linen.

77. The area of sterile field considered unsterile is:

    a. the inner proximal flap.
    b. the inner distal flap.
    c. the outer 6-inch margin.
    d. the outer 1-inch margin.

78. While a sterile dressing is being changed, the patient moves suddenly and the linen touches the forceps the nurse is using. The principle of asepsis that is involved here is:

a. the tips of the forceps must be pointed down.
b. sterile to unsterile is unsterile.
c. sterile to sterile is sterile.
d. reaching across the sterile field must be avoided.

79. The sequence for opening the flaps of the wrapper on a sterile package is:

a. proximal, distal, and two lateral flaps.
b. distal, proximal, and two lateral flaps.
c. two lateral, proximal, and distal flaps.
d. distal, two lateral, and proximal flaps.

80. When using the rules to maintain a sterile field, the nurse will do all except:

a. keep the area dry.
b. will not reach over the sterile field.
c. eliminate drafts from blowing over the sterile field.
d. keep hands below waist level.

81. Surgical asepsis differs from medical asepsis in that surgical asepsis:

a. confines a specific microorganism to a specific area.
b. keeps an area or object free of all microorganisms.
c. results in objects being made clean.
d. limits the number of microorganisms.

82. An individual who is more likely than others to acquire an infection is a(n):

a. etiologic agent.
b. vehicle.
c. vector.
d. susceptible host.

83. Immunity obtained by experiencing an illness is known as:

a. active, natural immunity.
b. passive, natural immunity.
c. active, acquired immunity.
d. passive, acquired immunity.

84. To control the transmission of pathogens, the nurse's most effective method is the use of:

    a. medical asepsis.
    b. surgical asepsis.
    c. isolation.
    d. terminal cleaning.

85. The only one of the following activities that is mandatory in all types of isolation is:

    a. wearing a nonsterile protective gown.
    b. wearing gloves when in contact with the patient.
    c. double-bagging items for disposal.
    d. hand washing when entering and leaving the room.

86. A patient must remain in reverse isolation until:

    a. the most virulent stage of the disease has passed.
    b. lab tests have identified the pathogen involved.
    c. his immunologic defenses are raised to adequate levels.
    d. antibiotic theory has reached on effective maintenance level.

87. Mr. Murray has been placed on isolation for enteric precautions. Which of the following measures should be observed?

    a. mask and gown worn by all who enter
    b. mask, gown, and gloves worn by all entering the room
    c. gown and gloves worn by the nurse if soiling likely
    d. door to the room must remain closed at all times

88. Mrs. Green has been diagnosed with tuberculosis. She is on respiratory isolation and coughing profusely. She is to go to radiology for a chest x-ray. Which of the following would be appropriate?

    a. portable x-ray should be done in her room
    b. gown and mask worn by patient, nurse, and radiology technician
    c. mask only worn by the patient
    d. patient cautioned to use tissues and cover nose and mouth when coughing

89. Mrs. Boatman was put on wound and skin isolation. After 2 days the nurse notices Mrs. Boatman had become irritable and was crying most of the time. Her family was unable to visit. Which of the following would be the best nursing intervention?

    a. physician's order for a sedation is needed
    b. encourage her to call her family for support while she is in the hospital
    c. visit with her as much and as frequently as possible
    d. allow her more privacy to vent her emotions

90. Of the following, which is NOT an element in the development or chain of infection?

    a. infectious agent or pathogen
    b. reservoir for pathogen growth
    c. means of transmission
    d. formation of immunoglobulins

91. A nurse wears elasticized stockings while working. At what time in the day should she put on the stockings?

    a. upon awakening before getting out of bed
    b. immediately before breakfast
    c. immediately before leaving for work
    d. when she is ready to report on duty

92. When applying an elastic bandage to a client's extremity:

    a. apply the bandage from the proximal to the distal aspect of the extremity.
    b. apply generous overlapping of bandage to avoid slippage.
    c. apply the bandage from the distal to the proximal aspect of the extremity.
    d. apply generous pressure to the bandage to avoid slippage.

93. A bandage is anchored at the first and final turn with which type of turn?

    a. circular
    b. spiral
    c. figure-eight
    d. recurrent

94. Which type of wound is most likely to heal by secondary intention?

    a. an appendectomy incision
    b. a laceration on the finger from a knife
    c. a scalp wound that requires suturing
    d. a deep burn on a hand

95. When cleansing an incision with a Penrose drain in the distal end, the nurse moves the cleansing swab from:

    a. the proximal end of the incision toward the distal end.
    b. the distal end of the incision toward the proximal end.
    c. the ends of the incision toward the center.
    d. the center of the incision toward each end.

96. The purpose of wearing clean gloves when removing a soiled dressing is to:

    a. prevent contamination of the nurse's hands.
    b. prevent contamination of the patient's wound.
    c. allow for ease in manipulation of the dressing.
    d. carry out aseptic technique.

97. A common complication of immobility that affects the urinary system is:

    a. uremia.
    b. stone formation.
    c. excessive urine formation.
    d. bladder spasms.

98. Which one of the following minerals in the body is lost in above average amounts during prolongs periods of immobility?

    a. iron
    b. calcium
    c. magnesium
    d. phosphorous

99. In an immobilized client, which of the following would increase the speed of skin breakdown?

    a. decreased muscle tone
    b. increased food intake
    c. dehydration and/or edema
    d. range of motion exercises

100. Decubitus ulcers form primarily as a result of:

    a. prolonged illness and/or disease.
    b. restricted mobility.
    c. nitrogen build-up in the underlying tissues.
    d. sloughing of the skin over bony prominences.

101. Which of the following is the best prevention of decubitus ulcers?

    a. sitting in a chair daily
    b. using flotation pillows and water mattress
    c. repositioning and keeping skin clean and dry
    d. sheepskins

102. In order to provide care to the dying client, it is imperative that the nurse:

    a. maintain a sense of detachment.
    b. agree with client's values and beliefs.
    c. recognize client's need to share the experience.
    d. accept the client's need to withdraw and be alone.

103. One of the major fears of the dying patient is that of:

- a. being awake and conscious to the end.
- b. being deserted and left alone to die.
- c. becoming addicted to the pain medication.
- d. not being missed by their loved ones.

104. When working in a helping relationship with a terminally ill person, most authorities agree that it is of prime importance to:

- a. listen to the patient.
- b. speak of pleasant things.
- c. avoid discussion about dying.
- d. encourage the patient to reminisce.

105. Kubler-Ross recommends that the health worker's role with the dying patient is to act as a catalyst while assisting the patient to:

- a. go through the stages of dying.
- b. skip unpleasant stages of dying.
- c. rely on his family for primary emotional support.
- d. substitute thoughts of death with thoughts of living.

106. Dysfunctional grieving indicates the client is:

- a. lacking a support system.
- b. failing to cope with a loss.
- c. progressing through grief work.
- d. attempting to overcome the loss.

107. A person thinks "this is not happening to me". Which of the stages of dying does this statement most accurately reflect?

- a. denial
- b. depression
- c. bargaining
- d. anger

108. Which of the following words best describes the role of the nurse when caring for a grieving family?

- a. advising
- b. supporting
- c. advocating
- d. sympathizing

109. In assisting the bereaved family, which of the following interventions are helpful?

   1. Encourage family members to protect children by avoiding any expression of grief in the child's presence.
   2. Encourage family members to use euphemisms ("Daddy has gone on a long trip.")
   3. Encourage professional support from the clergy.
   4. Reassure family members that certain symptoms, such as difficulty carrying out everyday tasks, are part of the grief process and don't indicate a mental illness
   5. Explain that grief is a necessary process which will involve emotional pain.

   a. 1, 3, 4, 5
   b. 3, 4, 5
   c. 2, 4, 5
   d. all of the above

110. Usually the preferred method of obtaining a urine specimen for comprehensive laboratory examination is:

   a. insertion of straight catheter.
   b. insertion of Foley catheter.
   c. routine voiding.
   d. clean-catch, midstream voiding.

111. The most dangerous complication of a condom catheter that is too tight is:

   a. skin irritation.
   b. urine leakage.
   c. restriction of urine flow.
   d. restriction of circulation.

112. Which of the following might you consider abnormal in your 40-year-old patient?

   a. urine output of 2000 cc a day
   b. urine specific gravity of 1.010
   c. albumin and glucose identified in urine specimen
   d. black stools from ferrous sulfate

113. Which one of the following persons will most likely have concentrated urine?

   a. the person whose diet is low in salt intake
   b. the person whose diet is low in protein content
   c. the person whose fluid intake consists mostly of fruit flavored drinks
   d. the person whose total fluid intake is lower than average in amount.

114. The amount of urine a healthy adult excretes in 24 hours is approximately between:

a. 400 ml-900 ml
b. 1000 ml-1500 ml
c. 2500 ml-3000 ml
d. none of the above

115. In which direction should a female patient be taught to move toilet tissue over the perineal area after using the bedpan?

a. back and forth across the perineal area
b. from below the genital area toward the symphysis pubis
c. from near the top of the genital area toward the rectum
d. in a circular motion from around the perineal area and ending at the urethral meatus

116. Which of the following exercises is most often recommended for persons with urinary incontinence?

a. doing sit-ups
b. doing push-ups
c. alternately contracting and relaxing the perineal muscles (Kegal exercises)
d. alternately contracting and relaxing the long thigh muscles

117. Which of the following actions is least conducive to promoting normal habits of elimination from the large intestine?

a. taking cleansing enemas regularly
b. having an intake of fruit each day
c. planning a daily time for elimination
d. observing a regular exercise schedule

118. Which one of the following diets is most likely to predispose to constipation?

a. a low-salt diet
b. a low-fiber diet
c. a high-calorie diet
d. a high-protein diet

119. If the defecation reflex is repeatedly ignored:

a. sensation becomes dulled and the reflex no longer occurs.
b. sensation becomes dulled and the interval between reoccurrences is longer.
c. irritation develops and the reflex becomes stronger.
d. irritation develops and the interval between reoccurrences is shorter.

120. If the nurse finds that a patient has had an abnormal bowel movement, s/he should:

   a. report it and record it.
   b. report and record it and save a specimen.
   c. report it and save a specimen.
   d. record it and save a specimen.

121. The stools of a client experiencing upper GI tract bleeding will usually appear what color?

   a. black
   b. clay colored
   c. bright red
   d. green

122. In assessing a client for possible constipation, which of the following would be essential information to collect?

   a. amount and type of bulk ingested
   b. client's work schedule
   c. normal elimination pattern
   d. amount of daily exercise

123. Which of the following findings is indicative of a fecal impaction?

   a. loss of desire to defecate
   b. alternating patterns of normal stool and diarrhea
   c. constipation with liquid fecal seepage
   d. absence of stool upon digital rectal exam

124. For ease when inserting a rectal suppository, the nurse should instruct the patient to:

   a. hold his/her breath during insertion.
   b. lie on his abdomen during insertion.
   c. breathe through his/her mouth during insertion.
   d. contract the external sphincter during insertion.

125. The order "enemas until clear" means that the enema returns must be:

   a. clear of formed stool.
   b. clear of feces.
   c. clear and colorless.
   d. clear and highly colored.

EXHIBIT F

Nursing Skills I

Associate Degree Nursing Program

Chippewa Valley Technical College

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing-Technical Program

COURSE SYLLABUS

COURSE: Nursing Skills I

COURSE NUMBER: 510-101　　CREDITS: 1

PREREQUISITES: Admission to the Nursing-Technical Program
Challenge option available

COURSE LEAD: Sonja Rathbun

RESOURCES:

Nursing Skills I Packet

Kozier, Barbara & Erb, Genora, Techniques in Clinical Nursing, 3rd edition, Addison-Wesley, 1989.

Lippincott Learning System, Fundamental Nursing Skills, J.B. Lippincott Co., Philadelphia-Toronto.

Vaughn, Dean, Medical Terminology, Damon Instructional Systems Division, 1983.

COURSE DESCRIPTION:

This competency-based course includes medical terminology and the demonstration or development of the basic motor skills needed to provide safe care to patients. The skills are learned through a variety of methods outlined in individual learning packets and are evaluated by an instructor for competence. Students must demonstrate competency in all of the motor skills before progressing to Section III (clinical component) of 510-110 Introduction to Nursing.

METHODS OF INSTRUCTION:

Competency-based instruction
Textbook assignments and/or handouts
Laboratory displays
Audiovisual materials
Instructor demonstrations
Laboratory practice

METHODS OF EVALUATION:

Performance tests, Self-checkoffs, Quizzes/Worksheets

USE OF SKILLS LAB

The lab will be open and staffed by at least one instructor Monday through Friday, 8:00 A.M.-4 P.M. Hours after 4:00 P.M. will be posted.

Viewing of audiovisuals may be done in the library, in the Phillips AV room (P109) or in the skills lab. Headsets are required in the lab so as not to disturb others.

You may practice for your performance tests at any time. To insure that a bed is available for your practice, you may sign up ahead for "independent practice". If you desire instructor assistance you may sign up for "supervised practice".

When you are ready to take your performance test, you will sign the "performance test" schedule. If unable to keep your appointment, notify instructor as soon as possible.

The equipment you will need will be in labeled cupboards. Your cooperation is expected in putting equipment away and always leaving the lab as you found it.

The lab instructor will be available to answer questions if she is not scheduled for a performance test or supervised practice.

Instructor demonstrations will be posted on Monday morning for each week, so check the bulletin board. They will usually be scheduled twice. You will be accountable for information given at each instructor demonstration.

GRADING

You will be graded according to the scores you achieve on your performance tests, written quizzes/worksheets and medical terminology final. In addition, to pass the course you must attend the instructor demonstrations and perform all the self-checkoffs.

PERFORMANCE TESTS

You are required to pass all performance tests at 90%. This means that for each ten steps of a performance test you are allowed one prompt (e.g., 20 steps = 2 prompts, 25 steps = 2 prompts). If you make a mistake but correct it independently, it will not count as a mistake. If you do not achieve 90%, you will be required to repeat the performance test until you do. The highest score you can achieve on a repeat test is 90%.

The written quizzes/worksheets will cover assigned reading and information taught during instructor demo. Quizzes will be taken at the end of the demonstration and will consist of 5-10 questions. The worksheets will be due the day after the instructor demonstration.

Your final grade will be your average score on the performance tests, written quizzes/worksheets, medical terminology final and performance of all self-checkoffs.

CHIPPEWA VALLEY TECHNICAL COLLEGE
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NURSING SKILLS I
Medical Terminology

Medical Terminology is a required part of Nursing Skills I and provides the student with a basic knowledge of the language of medicine and an understanding of how complex medical terms are formed. Credit will be given to students who have received a passing grade in Medical Terminology at Chippewa Valley Technical College within the past five (5) years.

Read Introduction to Medical Terminology, pages 11-15, before beginning the viewing. Students will view the following videos independently. Each takes approximately one hour. **Dial 5052 and ask for the appropriate MED number. Wait for channel number.**

MED 263	Medical Terminology #1
MED 264	Medical Terminology #2
MED 265	Medical Terminology #3
MED 266	Medical Terminology #4
MED 267	Medical Terminology #5
MED 268	Medical Terminology #6
MED 269	Medical Terminology #7
MED 270	Medical Terminology #8
MED 271	Medical Terminology #9
MED 272	Medical Terminology #10
MED 273	Medical Terminology #11
MED 274	Medical Terminology #12
MED 275	Medical Terminology II #1
MED 276	Medical Terminology II #2

Upon completion of the 14 videos, the student will make a lab appointment to take the Medical Terminology final 350 word test (pages 221-235). A score of 78% is needed to successfully pass this section of Nursing Skills I.

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NURSING SKILLS I
Challenge Option

Students enrolled in 510-101 will have the option of challenging Nursing Skills I if they are competent in all motor performances listed in Nursing Skills I.

In order to challenge Nursing Skills I in the lab, the student must first make an appointment with a laboratory instructor. You will need to bring a partner to perform the role of a patient in a few of the challenges.

The challenge exam will consist of a mock clinical situation during which you will be required to take vital signs, and perform a bed to wheelchair transfer using your partner as the patient. You will administer an enema using a mannequin. You will be required to perform at least one other procedure selected at random from the Nursing Skills I list.

In order to successfully challenge Nursing Skills I, the student must perform the assigned motor skills at 90% proficiency in a period of 1.5-2 hours. An unsuccessful challenge will mean that the student is required to take Nursing Skills I.

All students enrolled in 510-101 will be required to pass the medical terminology portion of Nursing Skills I.

**Bring Nursing Skills I packet to challenge exam.

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Nursing Skills I Packet

Name ______________________________

NURSING SKILLS I
STUDENT PERFORMANCE RECORD

Performance Tests	1st Attempt	2nd Attempt	3rd Attempt
1. Handwashing			
2. Making an Unoccupied Bed			
3. Making an Occupied Bed			
4. Performing a Bedbath, Giving a Back Rub			
5. Giving Perineal Care			
6. Cleaning Dentures			
7. Moving Patient Up in Bed			
8. Moving Patient to Side of Bed: Lateral Position			
9. Transferring Patient: Bed to Chair			
10. Transferring Patient: Bed to Wheelchair			
11. Positioning			
12. Performing Passive Range of Motion			
13. Use of Bedpan			
14. Administering an Enema			
15. Taking Oral Temperature, Pulse, Respiration			
16. Taking Rectal and Axillary Temperature			
17. Taking Temperature: Electronic			
18. Assessing Blood Pressure			
19. Demonstrating Isolation Precautions			
20. Applying Warm Moist Packs: K-Pad			

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Nursing Skills I Packet

Name ______________________________

NURSING SKILLS I
STUDENT PERFORMANCE RECORD

Instructor Demos

1. Use of Hospital Equipment; Type of Restraints
2. Making an Unoccupied Bed
3. Types of Baths and Showers
4. Hair, Nail and Foot Care
5. Changing Gown with IV
6. Oral Hygiene; Special Equipment
7. Use of Transfer Devices
8. Elimination Devices, Catheter Care, Condom Catheter
9. Applying TEDS, Ace Bandage

Self-Checkoffs

1. __________ Use of Hospital Equipment and Types of Restraints

2. __________ Changing Gown With IV

3. __________ Use of Hearing Aid

4. __________ Use of Transfer Devices

5. __________ Measuring Height and Weight

6. __________ Heimlich Maneuver

7. __________ Applying TEDS, Ace Bandage

Written Quiz/Worksheet

1. __________ Types of Baths and Showers

2. __________ Hair, Nail and Foot Care

3. __________ Oral Hygiene; Special Equipment

4. __________ Elimination Devices, Catheter Care, Condom Catheter

5. __________ Feeding the Patient

__________ Medical Terminology Final

CHIPPEWA VALLEY TECHNICAL COLLEGE
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Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Environmental Safety

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in use of equipment: hi-low bed side rails wheel locks wheelchair safety wheel locks footrests seat belt		Instructor Demo	Self-Checkoff
Types of restraints	Read Kozier & Erb, "Techniques in Clinical Nursing", pgs. 280-285		

Unit: Medical Asepsis

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in hand washing procedure.	Read Kozier pgs. 24-27 View MED 100 "Handwashing" (18 minutes)	Practice Skill	Pass Performance Test

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Nursing Skills I Packet
Performance Test

UNIT: MEDICAL ASEPSIS
Handwashing

	Satis. +	Unsatis. -
1. Remove jewelry.		
2. Stand without touching uniform to sink.		
3. Wet hands by holding under running water.		
4. Hold hands lower than elbows.		
5. Apply soap to the hands.		
6. Wash the palm, back and wrist of each hand using circular motions. Interlaces fingers and thumbs.		
7. Rinse the hands.		
8. Repeat washing and rinsing.		
9. Dry hands with paper towel.		
10. Turn off water with paper towel as barrier.		

Comments:

( ) Pass ( ) Fail

______________________________ ______________
Instructor's Signature Date

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Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Personal Care

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in making an unoccupied bed.	Read Kozier, pgs. 205-210, pgs. 214-215	Instructor demo Practice skill	Pass Performance Test
Student will demonstrate competency in making an occupied bed.	Read Kozier, pgs. 210-215 View MED 194 "Occupied Bed" (20 min.)	Practice skill	Pass Performance Test
Student will demonstrate competency in performing a bed bath.	Read Kozier, pgs. 192-195 View MED 109 "Performing a Bedbath" (18 min.)	Practice skill	Pass Performance Test (includes back rub)
Student will demonstrate competency in giving a backrub.	Read Kozier, pgs. 200-201 View MED 112 "Effects of Pressure and Techniques of Massage" (28 min.)	Practice skill	Pass Performance Test (with bed bath)
Student will demonstrate competency in giving perineal care.	Read Kozier, pgs. 198-200	Practice skill	Pass Performance Test
Student will identify critical elements for a tub bath, shower, partial bath and self with help bath.	Read Kozier, pgs. 192-193, 196 View MED 108 "Overview of Bathing" (20 min.)	Instructor demo	Pass Written Quiz/Worksheet
Student will explain the principles of good hair, nail and foot care.	Read Kozier, pgs. 145-158. 197-198 View MED 110 "Hair and Nail Care" (19 min.)	Instructor demo	Pass Written Quiz/Worksheet

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in changing a gown for patient with IV.	Read Kozier pgs. 202-203	Instructor Demo	Self-checkoff
Student will explain the principles of providing oral hygiene and use of special equipment.	Read Kozier, pgs. 165-167, 169-171	Instructor Demo	Written Quiz/ Worksheet
Student will demonstrate competency in cleaning dentures.	Read Kozier, pgs. 167-169 View MED 129 "Care of Dentures" (8 min.)	Practice skill	Pass Performance Test
Student will demonstrate competency in cleaning, inserting inserting and removing a hearing aid.	Read Kozier, pgs. 185-187	Lab Display	Self-checkoff

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Name ____________________

Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Unocçupied Bed

		Satisf. +	**Unsatis.** -
1.	Wash hands.	______	______
2.	Gather appropriate linen in order of use.	______	______
3.	Raise bed to good working height.	______	______
4.	Place mattress pad on mattress.	______	______
5.	Find center fold and place bottom sheet on near side of mattress; tuck in at top.	______	______
6.	Miter top corner and tuck along side.	______	______
7.	Find center fold of plastic drawsheet and tuck in on near side.	______	______
8.	Find center fold of drawsheet and tuck in on near side.	______	______
9.	Repeat on other side of bed, pulling tightly with knuckles up.	______	______
10.	Center top sheet on one side of bed.	______	______
11.	Center blanket/bedspread on top of sheet.	______	______
12.	Tuck in at bottom and miter corners.	______	______
13.	Make 6 inch cuff at top.	______	______
14.	Repeat on other side of bed.	______	______
15.	Place pillow into pillowcase, zipper side first.	______	______
16.	Open bed (as for ambulatory patient).	______	______

Comments:

_____ Pass   _____ Fail

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Instructor's signature   Date

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Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Occupied Bed

Instructions: Bring a partner to be your patient.

		Satisf. +	Unsatis. -
1.	Wash your hands.	______	______
2.	Gather linen inorder of use (include laundry bag for dirty linen).	______	______
3.	Identify the patient.	______	______
4.	Explain the procedure.	______	______
5.	Screen for privacy.	______	______
6.	Raise bed to working height.	______	______
7.	Remove the bedspread, fold and set aside, unless soiled.	______	______
8.	Place bath blanket over top sheet.	______	______
9.	Have patient hold top of bath blanket and pull out sheet. Place in laundry bag.	______	______
10.	Raise side rail on far side of bed.	______	______
11.	Assist patient to roll away from you; reposition pillow	______	______
12.	Loosen bottom linen and roll as close to patient as possible; plastic draw sheet can be placed over patient.	______	______
13.	Position half the bottom sheet; tuck at top and side.	______	______
14.	Reposition plastic draw sheet and tuck.	______	______
15.	Position half the cotton draw sheet and tuck.	______	______
16.	Roll clean bottom linen to middle of bed, against patient.	______	______
17.	Raise side rail on near side of bed.	______	______
18.	Assist patient to roll back, over all of the linens; reposition pillow.	______	______
19.	Lower side rail on opposite side of bed.	______	______
20.	Remove all soiled bottom linen; place in laundry bag.	______	______

		Satisf. +	Unsatis. -
21.	Tuck in bottom sheet, plastic draw sheet and cotton draw sheet.		
22.	Return patient to supine position; lower side rail.		
23.	Place clean top sheet over patient.		
24.	Have patient hold sheet as you pull out bath blanket.		
25.	Place bedspread over top sheet; make 6 inch cuff at top.		
26.	Tuck sheet and bedspread at bottom and miter corner.		
27.	Repeat on other side.		
28.	Remove pillow and apply clean pillowcase; replace pillow.		
29.	Loosen top linen over patients feet.		
30.	Raise side rails if appropriate.		
31.	Lower the bed.		
32.	Replace call light if appropriate.		
33.	Place personal articles within reach.		
34.	Remove soiled linen.		
35.	Wash your hands.		

Comments:

_____ Pass _____ Fail

________________________________ ________________________
Instructor's signature Date

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Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Bed Bath

Instructions: Bring a partner to lab to be your patient. Have partner bring deodorant or special soap, if desired. Your patient will wear a hospital gown and underpants. You will need the following items of linen:

2 bath towels
2 wash cloths (one for washing, one for rinsing)
1 patient gown
1 bath blanket
1 laundry bag

		Satisf. +	**Unsatis.** -
1.	Wash your hands.		
2.	Assemble equipment.		
3.	Identify patient.		
4.	Explain the procedure.		
5.	Screen for privacy.		
6.	Raise the bed to working height.		
7.	Offer bedpan or urinal before you begin bath.		
8.	Remove top linen and replace with bath blanket.		
9.	Raise both side rails.		
10.	Fill basin with warm water. Lower bed if you leave the room; change water as necessary during bath.		
11.	Remove patient's gown.		
12.	Proceed with the bath in the following order, using a bath mitt to wash and rinse.		
	a. face, neck, ears (wash eyes separately)		
	b. arm (one arm only for this test): place towel lengthwise under arm; wash, rinse, and dry arm including axilla		
	c. hands: place towel on bed; put basin on it; place patient's hands in basin, assist as necessary.		
	d. chest: lower bath blanket to waist; place towel across chest; wash, rinse and dry chest/breasts.		
	e. abdomen: lower bath blanket to pubis, leaving towel across chest; wash, rinse & dry abdomen.		

		Satisf. +	Unsatis. -
f.	leg (one leg only for this test): flex leg at knee; place towel lengthwise under leg; wash, rinse and dry leg.		
g.	foot (one foot only for this test): place towel on bed; put basin on it; place foot in basin and wash, rinse and dry foot, being careful to dry between toes.		
h.	Pull up side rail; change water.		
i.	Lower side rail.		
j.	Assist patient to side lying position and place towel lengthwise along back.		
k.	Wash, rinse and dry back and buttocks.		
l.	Wash, rinse and dry rectal area (set aside contaminated washcloth and do not use again).		
m.	Give back rub (see BACK RUB: PERFORMANCE TEST).		
n.	Raise side rail; change water.		
o.	Lower side rail, assist patient to supine position.		
p.	Perineal care would now be given (procedure will be done as a separate test).		
13.	Assist patient to use deodorant, powder, etc.		
14.	Help the patient put on a clean gown.		
15.	Assist with hair and nail care. (Verbalize)		
16.	Offer mouth care if not given before. (Verbalize)		
17.	Wipe tray table and bedside stand with wet paper towel and dry.		

Comments:

_____ Pass _____ Fail

______________________________ Instructor's signature

______________________________ Date

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ASSOCIATE DEGREE NURSING

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Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Giving a Back Rub

		Satisf. +	Unsatis. -
1.	Wash your hands.		
2.	Assemble equipment.		
3.	Identify patient.		
4.	Explain the procedure.		
5.	Screen for privacy.		
6.	Raise bed to working height.		
7.	Assist patient to prone or side lying position.		
8.	Expose the back.		
9.	Pour small amount of lotion onto the palms of your hands and hold it for a minute to warm it.		
10.	Rub in a circular motion over sacral area.		
11.	Move your hands up the center of back and over both scapulae.		
12.	Massage in circular motion over both scapulae.		
13.	Move your hands down the sides of the back.		
14.	Massage areas over right and left iliac crest and coccyx.		
15.	Repeat 2-3 times, reapplying lotion as necessary.		
16.	Observe for redness, broken or raw skin.		

Comments:

_____ Pass   _____ Fail

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Instructor's signature

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Date

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Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Giving Perineal Care

	Satisf. +	Unsatis. -
1. Wash your hands.	______	______
2. Assemble equipment. (Gloves optional)	______	______
3. Identify patient.	______	______
4. Explain the procedure.	______	______
5. Screen for privacy.	______	______
6. Raise bed to working height.	______	______
FEMALE:		
7. Position patient on her back with knees flexed, legs apart.	______	______
8. Expose perineal area, keeping legs covered.	______	______
9. Don gloves, separate labia and wash from front to back; rinse and dry.	______	______
10. Wash, rinse and dry labia majora.	______	______
11. Wash, rinse and dry inner thighs.	______	______
12. Inspect for redness or irritation.	______	______
13. Apply protective ointments as necessary.	______	______
MALE:		
14. Position patient on back with knees slightly flexed, legs slightly apart.	______	______
15. Don gloves and wash, rinse and dry the penis starting with urinary meatus; retract foreskin if uncircumcised.	______	______
16. Wash, rinse and dry the scrotum.	______	______
17. Wash, rinse and dry inner thighs.	______	______
18. Inspect for redness or irritation.	______	______
19. Apply protective ointments as necessary.	______	______

Comments:

______ Pass ______ Fail

______________________________ Instructor's Signature

______________________ Date

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Nursing Skills I Packet
Performance Test

UNIT: PERSONAL CARE
Cleaning Dentures

		Satisf. +	Unsatis. -
1.	Wash your hands.		
2.	Assemble equipment.		
3.	Identify patient.		
4.	Explain the procedure.		
5.	Screen for privacy.		
6.	Don gloves. (Optional)		
7.	Have patient remove dentures & place in denture cup OR grasp upper plate with thumb & second finger & move up and down to break suction. (Verbalize)		
8.	Remove from mouth and place in denture cup. (Verbalize)		
9.	Remove lower plate and place in denture cup. (Verbalize)		
10.	Take dentures to sink.		
11.	Place emesis basin in sink and place dentures in emesis basin.		
12.	Adjust water to tepid and let run.		
13.	Cup denture in hand and brush with toothbrush and cleaning agent, holding over emesis basin.		
14.	Rinse under running water.		
15.	Place in rinsed out denture cup.		
16.	Repeat with other denture.		
17.	Clean mouth including tongue, gums and cheeks with soft toothbrush or swabs. (Verbalize)		
18.	Allow patient to rinse mouth. (Verbalize)		

	Satisf. **+**	**Unsatis.** **-**
19. Have patient replace dentures in mouth **OR** insert them in mouth, one at a time. (Verbalize)	______	______

NOTE: If patient does not wish to wear dentures, fill cup with water and place in drawer of bedside stand.

Comments:

______ Pass ______ Fail

______________________________ ______________________________
Instructor's signature Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Mobility

*Good body mechanics are expected during performance tests.

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in moving patient up in bed.	Read Kozier pgs. 223-225 View MED 324 "Lifting and Moving the Patient" (17 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in moving patient to the side of bed in segments and to a lateral position.	Read Kozier pgs. 226-228 View MED 116 "Assist to Move in Bed" (12 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in transferring a patient from a bed to a chair.	Read Kozier pgs. 232-237 View MED 119 "Assist Patient to Ambulate" (10 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in transferring a patient with an injured left arm and leg to a wheelchair (2 nurses).	Read Kozier pgs. 232-237 View MED 120 "Assist Patient to Wheelchair" (11 min.) View MED 46 (three parts)	Practice Skill	Pass Performance Test
Student will demonstrate competency in transferring a patient using: stretcher smooth mover 3-man carry Hoyer lift walker transfer belt	Read Kozier pgs. 237-239 pgs. 264-268 View MED 117 "Assist: from Stretcher" (11 min.)	Instructor Demo	Self-Checkoff

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in supporting patient in following positions: Fowler's dorsal recumbent prone lateral Sims'	Read Kozier pgs. 243-252 View MED 121 "Basic Positions" (12 min.) View MED 122 "Assistive Devices" (11 min.)	View lab display of assistive devices Practice skill	Pass Performance Test
Student will demonstrate competency in performing passive range of motion.	Read Kozier pgs. 255-263 View MED 168 "Range of Motion: Passive" (17 min.)	Practice skill	Pass Performance Test

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Name ______________________________
Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Moving a Patient Up in Bed with Patient Assisting

INSTRUCTIONS: Bring a partner to be your patient.

	Satis. +	**Unsatis.** -
1. Wash your hands.		
2. Identify the patient.		
3. Explain the procedure.		
4. Screen for privacy.		
5. Raise the bed to working height, in flat position.		
6. Place the patient's pillow against the head of the bed.		
7. Instruct patient to flex knees and place feet flat on bed.		
8. Position yourself with your feet pointing toward the head of the bed, knees flexed.		
9. Place one arm under the patient's shoulders and the other arm under patient's thighs.		
10. Instruct patient to push with his/her hands.		
11. Instruct the patient that on the count of three you will both move simultaneously.		
12. Move the patient up in bed on the count of three.		
13. Replace pillow under patient's head.		
14. Raise side rails and lower bed.		

MOVING A PATIENT UP IN BED WHO IS UNABLE TO ASSIST (2 NURSES)

1. Place the patient's pillow against the head of the bed.		
2. Place a drawsheet under the patient, between hips and shoulders (drawsheet should be folded in half the short way).		
3. Flex patient's knees and place feet flat on bed.		
4. Fold the patient's arms across his/her chest.		

	Satis. +	Unsatis. -
5. Roll up the drawsheet close to the patient.	______	______
6. On the count of three, lift patient toward the head of the bed.	______	______
7. Replace pillow under patient's head.	______	______
8. Raise side rails and lower bed.	______	______

Comments:

_____ Pass _____ Fail

______________________________ ______________

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Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Moving a Patient to the Side of the Bed in Segments

INSTRUCTIONS: Bring a partner to be your patient.

	Satis. +	Unsatis. -
1. Wash your hands.		
2. Identify the patient.		
3. Explain the procedure.		
4. Screen for privacy.		
5. Raise the bed to working height, in flat positon.		
6. Face bed and stand with wide-base of support.		
7. Place patient's arms over chest.		
8. Place one arm under the shoulder of the patient and the other under the waist.		
9. Rock backward pulling the patient's shoulders toward you.		
10. Place one arm under the waist and one arm under the upper thigh and move toward you.		
11. Place hands beneath patient's ankles and move toward you.		
12. Replace pillow under patient's head.		

*Patient is now ready to be placed in lateral position.

MOVING A PATIENT TO A LATERAL POSITION

	Satis. +	Unsatis. -
1. Stand on side of bed nearest patient.		
2. Place patient's near arm across chest.		
3. Place the far arm away from patient's body, either straight or with elbow flexed.		
4. Place the patient's near ankle and foot across the far ankle and foot.		
5. Raise side rail and go to far side of bed.		

	Satis. +	Unsatis. -
6. Place hands on patient's shoulder and hips.	______	______
7. Roll patient toward you.	______	______
8. Raise side rail and lower bed.	______	______

Comments:

_____ Pass _____ Fail

Instructor's signature ______________________ Date ______________________

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Ambulating a Weak Patient From Bed to a Chair

INSTRUCTIONS: Bring a partner to be your patient.

		Satis. +	Unsatis. -
1.	Wash your hands.		
2.	Identify patient.		
3.	Explain the procedure.		
4.	Screen for privacy.		
5.	Lower bed and lock wheels.		
6.	Provide robe, shoes, sox, and transfer belt.		
7.	Place folded bath blanket over back and seat of chair.		
8.	Raise head of bed and lower side rail.		
9.	Pivot the patient to a sitting position at side of bed.		
10.	Assess patient's condition.		
11.	Help patient put on robe and shoes and socks/slippers.		
12.	Apply transfer belt snugly around patient's waist.		
13.	Ask the patient to place his/her hands on the bed surface and push to stand up.		
14.	Steady patient by holding onto transfer belt.		
15.	Walk with patient to chair, supporting as necessary.		
16.	Have patient touch chair with back of legs and arm of chair with hand.		
17.	Assist him/her to sit down.		
RETURN TO BED			
18.	Have patient move to edge of chair.		
19.	Have patient grasp arms of chair to help raise him/her up.		
20.	Steady patient by holding transfer belt.		

	Satis. +	Unsatis. -
21. Walk with patient to bed and help pivot him/her so that back is toward bed.		
22. Have patient reach for bed with hands, while still supporting him/her.		
23. As patient sits down, lift up robe so he/she does not sit on it.		
24. Remove transfer belt, robe, shoes and socks.		
25. Assist patient to lie down.		
26. Make patient comfortable.		
27. Raise side rail.		

Comments:

_____ Pass _____ Fail

Instructor's signature

Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Transferring Patient With Injured Left Arm and Leg to Wheelchair (Using Two Nurses)

Instructions: Bring a partner to be your patient.

	Satis. +	Unsatis. -
1. Wash your hands.	______	______
2. Identify patient.	______	______
3. Explain the procedure.	______	______
4. Screen for privacy.	______	______
5. Lower bed and lock wheels.	______	______
6. Provide robe, shoes and socks/slippers, and transfer belt.	______	______
7. Remove foot rests from wheelchair or swing to the side; lock wheels.	______	______
8. Place the wheelchair on the patient's strong (unaffected side).	______	______
9. Raise head of bed and lower side rail.	______	______
10. Pivot the patient to a sitting position (one nurse with arm behind shoulders, other nurse guiding patient's legs).	______	______
11. Assess patient's condition.	______	______
12. Help patient put on robe by starting with injured arm first; then shoes, socks, and transfer belt.	______	______
13. Nurse on injured side stabilizes patient's leg with his/her foot and knee; holds transfer belt and supports arm and shoulder.	______	______
14. Nurse on unaffected side holds onto transfer belt.	______	______
15. Both assist patient to a standing position.	______	______
16. Nurse on unaffected side then guides patient's hand to arm of wheelchair.	______	______
17. Assist the patient to pivot and sit down.	______	______
18. Apply restraint or seat belt as ordered.	______	______

RETURN TO BED

	Satis. +	Unsatis. -
19. Place the wheelchair so patient can lead with his/her unaffected side; lock the wheels; nurses position themselves as before.		
20. Stand patient and pivot to edge of bed.		
21. As patient sits down, lift up robe so he/she does not sit on it.		
22. Remove transfer belt.		
23. Remove robe by starting with unaffected arm first.		
24. Remove shoes and socks.		
25. Pivot to a lying down position.		
26. Make patient comfortable.		
27. Raise side rail.		

Comments:

_____ Pass _____ Fail

Instructor's signature

Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Positioning

Instructions: Student will be expected to show competence in three (3) positions, chosen at random by instructor. Bring a partner to be your patient.

		Satis. +	**Unsatis.** -
1.	Wash your hands.	______	______
2.	Identify patient.	______	______
3.	Explain the procedure.	______	______
4.	Screen for privacy.	______	______
5.	Raise bed to working height.	______	______
FOWLERS			
6.	Raise the head of the bed to 45°.	______	______
7.	Place small pillow or roll under lumbar region if you feel a space.	______	______
8.	Place pillow under patient's head.	______	______
9.	Place one or two pillows (or bath blanket) under lower legs, so heels are not touching bed.	______	______
10.	Support patient's feet with a footboard.	______	______
DORSAL RECUMBENT			
1.	Place patient on back with bed flat.	______	______
2.	Place pillow behind head and shoulders.	______	______
3.	Place pillow under lower legs, so heels are not touching bed.	______	______
4.	Place trochanter rolls against femurs.	______	______
5.	Place small pillow or roll under lumbar region if needed.	______	______
6.	Support patient's feet with a footboard.	______	______
7.	Elevate patient's forearms and hands (when indicated).	______	______
8.	Apply handrolls (when indicated).	______	______

	Satis. +	Unsatis. -
PRONE		
1. Assist patient to a prone position.	______	______
2. Turn head to side and provide small pillow if desired.	______	______
3. Place small pillow or roll under abdomen.	______	______
4. Place pillow under lower legs, avoiding pressure on the toes, or feet may extend over edge of mattress.	______	______
LATERAL		
1. Assist patient to a lateral position.	______	______
2. Place pillow under patient's head.	______	______
3. Properly position lower shoulder.	______	______
4. Support upper arm with pillow.	______	______
5. Place pillow between legs for good alignment.	______	______
6. Place rolled pillow at back to stabilize position.	______	______
SIMS		
1. Turn the patient to semi-prone position.	______	______
2. Place pillow under patient's head.	______	______
3. Place lower arm behind patient's body if tolerated.	______	______
4. Place a pillow to support upper arm and chest.	______	______
5. Place pillow beneath upper thigh.	______	______

Comments:

_____ Pass _____ Fail

______________________________ Instructor's signature

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________
Nursing Skills I Packet
Performance Test

UNIT: MOBILITY
Performing Passive Range of Motion

Instructions: Bring a partner to be your patient. Each movement will be done once for this test.

	Satis. +	**Unsatis.** -
1. Wash hands.	______	______
2. Identify patient.	______	______
3. Explain the procedure.	______	______
4. Screen for privacy.	______	______
5. Raise the bed to working height; lower side rail.	______	______
6. Assist patient to a supine position.	______	______
7. Flex and extend the shoulder.) 8. Abduct and adduct the shoulder. > 9. Rotate shoulder internally, externally)	______	______
10. Flex and extend the elbow.) 11. Pronate and supinate forear >	______	______
12. Hyperextend and flex the wrist.) 13. Flex and extend the fingers. > 14. Abduct and oppose the thumb.)	______	______
15. Flex and extend hip and knee.) 16. Abduct and adduct leg. > 17. Rotate hip internally and externally.)	______	______
18. Dorsiflex and plantar flex the foot.) 19. Invert and evert the foot. > 20. Flex and extend the toes.)	______	______
21. Flex and extend the neck.) 22. Laterally flex the neck. > 23. Lower bed and raise side rail.)	______	______

Comments:

_____ Pass _____ Fail

____
Instructor's signature

____
Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Elimination

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will identify types of bedpans, urinal, top-hat, commode.	Read Kozier pgs. 406-410	Instructor Demo	Written Quiz/ Worksheet includes 1) elimination devices 2) catheter care 3) condom catheter
Student will identify types of specimen containers.	Read Kozier pgs. 94-95, 101-103	Lab Display	
Student will explain the procedure for catheter care.	Read Kozier pgs. 440-441	Instructor Demo	
Student will explain the procedure for applying a condom catheter.	Read Kozier pgs. 448-450	Instructor Demo	
Student will demonstrate competency in giving and removing a bedpan.	Read Kozier pgs. 406-410 View MED 118 "Assist Patient on a Bedpan" (11 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in administering an enema.	Read Kozier pgs. 412-416 View MED 134 "Enema Administration Practice" (13 min.)	Practice Skill	Pass Performance Test

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills I Packet
Performance Test

UNIT: ELIMINATION
Giving and Removing a Bedpan

Instructions: Bring a partner to be your patient. (Use of gloves is recommended.)

FOR PATIENTS WHO CAN ASSIST:	Satis. +	Unsatis. -
1. Wash your hands.	______	______
2. Assemble equipment (warm the bedpan).	______	______
3. Identify patient.	______	______
4. Explain the procedure.	______	______
5. Screen for privacy.	______	______
6. Fold back bedclothes without exposing patient and ask patient to flex his/her knees and raise his/her buttocks.	______	______
7. Place the patient on the bedpan.	______	______
8. Raise the head of the bed.	______	______
9. Give patient the call light and toilet paper, if appropriate.	______	______
10. Raise side rail.	______	______
REMOVING A BEDPAN		
11. Lower the head of the bed.	______	______
12. Assist the patient to clean him/herself. (Verbalize)	______	______
13. Ask patient to raise his/her buttocks and remove bedpan.	______	______
14. Cover the bedpan and place on chair or at foot of bed.	______	______
15. Allow patient to wash hands (if appropriate).	______	______
16. Empty and clean bedpan.	______	______

		Satis. +	Unsatis. -
	FOR PATIENTS WHO ARE HELPLESS:		
18.	Turn patient on his/her side, away from you.		
19.	Place the bedpan against buttocks.		
20.	Roll patient back onto bedpan (adjust as necessary).		
21.	Raise the head of the bed.		
22.	Give patient the call light and toilet paper, if appropriate.		
23.	Raise side rail and lower bed, if you leave the bedside.		
	REMOVING THE BEDPAN		
24.	Lower the head of the bed.		
25.	Clean perineal area if necessary. (Verbalize)		
26.	Roll the patient to his/her side while holding the bedpan securely.		
27.	Remove bedpan, cover and place on chair or at foot of bed.		
28.	Clean the rectal area if necessary. (Verbalize)		
29.	Wash patient's hands (if appropriate).		
30.	Raise side rails and lower bed.		
31.	Empty and clean bedpan.		

Comments:

_____ Pass _____ Fail

Instructor's signature

Date

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Name ____________________

Nursing Skills I Packet
Performance Test

UNIT: ELIMINATION
Administering an Enema

		Satis. +	**Unsatis.** -
1.	Verify physicians order.	______	______
2.	Wash hands.	______	______
3.	Identify patient.	______	______
4.	Explain the procedure.	______	______
5.	Screen for privacy.	______	______
6.	Assemble equipment and prepare at sink. (1000 cc H_2O, temp $100\text{-}105^0$, expel air and lubricate tip.) a) enema kit b) graduate c) bath thermometer d) lubricant e) exam gloves	______	______
7.	Raise bed to working height and lower side rail.	______	______
8.	Assist patient to left Sim's position (lateral).	______	______
9.	Place waterproof pad under buttocks.	______	______
10.	Make certain bedpan & toilet paper are available.	______	______
11.	Instruct patient to deep breathe.	______	______
12.	Don gloves and insert rectal tube 3-4 inches directing toward umbilicus.	______	______
13.	Open clamp and raise solution container to 12-18" above rectum.	______	______
14.	Administer fluid slowly. If cramping occurs, stop flow and restart slowly.	______	______
15.	Close clamp and remove rectal tube.	______	______
16.	Encourage client to retain solution 5-10 minutes.	______	______
17.	Assist the client to sitting position on bedpan, commode, or to bathroom.	______	______
18.	Observe and report results.	______	______

Comments:

_____ Pass _____ Fail

______________________________ Instructor's signature

______________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Vital Signs

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in taking oral temperature, pulse, and respiration (TPR).	Read Kozier pgs. 63-70 73-75 79-80 View MED 328 "Temperature, Pulse and Respiration"	Pratice Skill	Pass Performance Test
Student will demonstrate competency in taking rectal and axillary temperature.	Read Kozier pgs. 68-70	Practice Skill	Pass Performance Test
Student will demonstrate competency in taking a temperature with the electronic thermometer.	Read Kozier pgs. 68-70 View MED 179 "Taking a Temperature: Electronic" (25 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in measuring height and weight.	Read Kozier pgs. 56-61	Practice Skill	Self-Checkoff
Student will demonstrate competency in assessing a blood pressure.	Read Kozier pgs. 81-87 View MED 178 "Assessing Arterial Blood Pressure" (19 min.) View MED 23 "Reading the Blood Pressure Manometer" (write answers on scratch paper)	Practice Skill (required to take blood pressure of 10 people and graph before Performance Test.)	Pass Performance Test

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will identify the rationale for skills learned in "Vital Signs" unit.	Review learning activities for "Vital Signs".		Take Quiz

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills I Packet
Performance Test

UNIT: VITAL SIGNS
Taking Temperature (Oral), Pulse and Respiration

Instructions: Bring a partner to be your patient.

	Satis. +	**Unsatis.** -
1. Wash hands.	______	______
2. Assemble equipment.	______	______
3. Identify patient.	______	______
4. Explain the procedure.	______	______
5. Check thermometer reading to make sure it is below 95F (35C).	______	______
6. Apply disposable sheath.	______	______
7. Make sure patient hasn't taken fluids or smoked for 15 minutes.	______	______
8. Place thermometer bulb at base of tongue.	______	______
9. Instruct patient to close lips.	______	______
10. Leave thermometer in place for 3 minutes.	______	______
11. Instruct patient that pulse is to be taken along with temperature.	______	______
12. Position patient's arm on a flat surface at level of heart.	______	______
13. Exert firm pressure over radial artery and count pulse for 30 seconds or full minute if irregular.	______	______
14. With fingers still on wrist, count respirations for 30 seconds or full minute if irregular.	______	______
15. Remove thermometer and peel off disposable sheath.	______	______
16. Read thermometer accurately.	______	______
17. Immediately record TPR on note pad in proper order.	______	______
18. Return thermometer to proper place.	______	______
19. Wash hands.	______	______
20. Evaluate pulse and respiration for rate, rhythm and quality.	______	______
21. Report deviations; record on graphic sheet.	______	______

Comments:

_____ Pass _____ Fail

______________________________ ________________
Instructor's signature Date

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SACRED HEART HOSPITAL
Eau Claire, Wisconsin

GRAPHIC CHART

02-2-396

Nursing Skills I Packet
Appendix A

	Date														
	Day of Hos.														
	Day of Surgery														
	Time	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
TEMPERATURE	105°														
	104°														
	103°														
	102°														
	101°														
	100°														
	99°														
	98°														
	97°														
	Pulse														
	Respiration														
	Blood Pressure														
	Weight & Height														
	Diet														
	Appetite														
	Bath														
	Sleep														
	Stool														
		P.O.	I.V.	P.O.	I.V.	P.O.	I.V.	P.O.	I.V.	P.O.	I.V.	P.O.	I.V.	P.O.	I.V.
INTAKE	11-7														
	7-3														
	3-11														
	24Hr TOTAL														
		U.		U.		U.		U.		U.		U.		U.	
OU	11-7														
	7-3														
	3-11														
	24Hr TOTAL														
NURSES	11-7														
	7-3														
SIGNATURE	3-11														

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SACRED HEART HOSPITAL
EAU CLAIRE, WISCONSIN

BLOOD PRESSURE GRAPH 02-2-388

Nursing Skills I Packet
Appendix B

Date
Time
260
250
240
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
Pulse
Resp.

SACRED HEART HOSPITAL
Eau Claire, Wisconsin

GRAPHIC CHART

02-2-396

Nursing Skills I Packet
Appendix A

Date														
Day of Hos.														
Day of Surgery														
Time	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
TEMPERATURE 105°														
104°														
103°														
102°														
101°														
100°														
99°														
98°														
97°														
Pulse														
Respiration														
Blood Pressure														
Weight & Height														
Diet														
Appetite														
Bath														
Sleep														
Stool														

		P.O.	I.V.		P.O.	I.V.		P.O.	I.V.		P.O.	I.V.		P.O.	I.V.		P.O.	I.V.		P.O	I.V	
INTAKE	11-7																					
	7-3																					
	3-11																					
	24Hr TOTAL																					
		U.			U.			U.			U.			U.			U.			U.		
[illegible]TPUT	11-7																					
	7-3																					
	3-11																					
	24Hr TOTAL																					

NURSES	11-7							
	7-3							
SIGNATURE	3-11							

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills I Packet
Performance Test

UNIT: VITAL SIGNS
Taking a Temperature: Rectal, Axillary

		Satis. +	Unsatis. -
1.	Wash hands.		
2.	Assemble equipment (gloves optional).		
3.	Identify patient.		
4.	Explain procedure.		
5.	Screen for privacy.		
RECTAL TEMPERATURE			
6.	Raise bed to working height; lower side rail.		
7.	Check thermometer and shake down to below 95F (35C).		
8.	Lubricate about one inch of bulb end.		
9.	Assist patient to lateral position.		
10.	Lift top buttock and insert thermometer one-half to one inch into rectum.		
11.	HOLD thermometer in place 2 minutes.		
12.	Remove thermometer and wipe downward from tip to bulb.		
13.	Reposition patient.		
14.	Raise side rails and lower bed.		
15.	Read thermometer and return to container.		
16.	Wash hands.		
17.	Record rectal temperature reading (R) on graphic sheet and report deviations. [An (R) on graphic sheet indicates rectal reading.]		

AXILLARY TEMPERATURE

	Satis. +	Unsatis. -
1. Assist patient to comfortable position.	______	______
2. Check thermometer to make sure it's below 95F (35C).	______	______
3. Place thermometer into axillary cavity.	______	______
4. Draw patient's arm across chest.	______	______
5. Leave thermometer in place for 9 minutes.	______	______
6. Remove thermometer.	______	______
7. Wipe from tip to bulb.	______	______
8. Read thermometer and return to container.	______	______
9. Wash hands.	______	______
10. Record axillary temperature reading (AX) and report deviations. [An (AX) on graphic sheet indicates axillary reading.]	______	______

Comments:

_____ Pass _____ Fail

_______________________________ _______________

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills I Packet
Performance Test

UNIT: VITAL SIGNS
Taking Temperature: Electronic Thermometer

Instructions: Bring a partner to be your patient.

	Satis. +	Unsatis. -
1. Wash hands.		
2. Assemble equipment		
3. Identify patient.		
4. Explain procedure.		

ORAL TEMPERATURE

	Satis. +	Unsatis. -
5. Make sure oral probe is connected to unit.		
6. Check unit for number completeness.		
7. Put disposable cover on probe.		
8. Make certain patient hasn't taken fluids or smoked for 15 minutes.		
9. Place thermometer probe at base of tongue.		
10. Hold the probe under tongue until maximum temperature registers and read.		
11. Discard probe cover properly; replace probe in unit.		
12. Record temperature accurately (on graphic sheet).		
13. Return unit to proper location.		
14. Do not set down in patient's environment.		

AXILLARY TEMPERATURE (Verbal Explanation)

	Satis. +	Unsatis. -
1. Make sure oral probe is connected to unit.		
2. Check unit for number completeness.		
3. Put disposable cover on probe.		
4. Insert probe parallel to body deep in center of axilla.		
5. Assist patient to place arm across chest.		

	Satis. +	Unsatis. -
6. Read temperature after it completes registering.		
7. Remove thermometer.		
8. Discard probe cover and replace probe in unit.		
9. Record temperature accurately.		
10. Return unit to proper location.		
11. Do not set down in patient's environment.		

RECTAL TEMPERATURE (Verbal Explanation)

	Satis. +	Unsatis. -
1. Screen for privacy.		
2. Raise bed to working height and lower side rail.		
3. Make sure rectal probe is connected to unit.		
4. Check unit for number completeness.		
5. Assist patient to lateral position.		
6. Ask patient to take a deep breath and insert lubricated probe (one-half inch) into rectum.		
7. Hold thermometer in place until it registers.		
8. Read temperature on readout.		
9. Remove thermometer and record temperature accurately.		
10. Wrap probe cover in paper towel and discard; replace probe in unit.		
11. Assist patient to comfortable position.		
12. Raise side rails and lower bed.		

Comments:

_____ Pass _____ Fail

Instructor's Signature

Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills I Packet
Performance Test

UNIT: VITAL SIGNS
Assessing Blood Pressure

INSTRUCTIONS: Bring a partner to be your patient.

		Satis. +	Unsatis. -
1.	Wash hands.		
2.	Assemble equipment.		
3.	Identify patient.		
4.	Explain the procedure.		
5.	Position the patient with arm at heart level.		
6.	Wrap cuff snugly around upper arm OR		
	a. palpate brachial artery.		
OPTIONAL	b. close valve on pump.		
	c. pump up cuff until you no longer feel brachial pulse.		
	d. note the pressure at which pulse is no longer felt.		
	e. release pressure completely and wait 1-2 minutes before taking blood pressure.		
7.	Verify BP verbally or with patient's chart.		
8.	Place ear pieces of stethescope in ears.		
9.	Place diaphragm of stethescope over brachial pulse.		
10.	Close valve and inflate cuff approximately 30 mm above systolic reading.		
11.	Release valve carefully and read manometer as pressure decreases (systolic is first tapping sound; diastolic is point where sounds become inaudible).		
12.	Deflate cuff completely.		
13.	Remove from patient's arm.		

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	Satis. +	Unsatis. -
14. Record blood pressure (on graphic) and report any changes. (Reading must be within 4 mm of instructors.)	_____	_____

Comments:

_____ Pass _____ Fail

__________________________________ _______________
Instructor's signature Date

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Assignment Sheet

CAREGIVER ROLE
Unit: **Medical Asepsis**

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in isolation precautions.	Read Kozier pgs. 27-33 AND Read "Universal Precautions" inside front cover View MED 107 "Isolation" (29 min.)	Practice Skill	Pass Performance Test

Unit: Oxygenation

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in performing Heimlich Maneuver	Read Kozier pgs. 704-707	View "How to Save a Choking Victim" (18 min) Group view as scheduled Practice Skill on "Choking Charlie"	Self-Checkoff

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills I Packet
Performance Test

UNIT: MEDICAL ASEPSIS
Isolation Precautions

	Satisf. +	Unsatis. -
DONNING A FACE MASK:		
1. Wash hands.	____	____
2. Place upper edge of mask over bridge of nose and tie behind head.	____	____
3. Place lower edge of mask under chin and tie at nape of neck.	____	____
DONNING A GOWN:		
1. Wash hands.	____	____
2. Pick up clean gown and allow it to unfold.	____	____
3. Slide arms and hands through sleeves.	____	____
4. Fasten ties at back of neck.	____	____
5. Overlap gown at the back and fasten waist ties.	____	____
DONNING DISPOSABLE GLOVES:		
1. Wash hands.	____	____
2. Put gloves on hands.	____	____
3. Pull gloves up to cover the cuffs of the gown.	____	____
DOUBLE BAGGING: (Bring a partner to be your "clean" nurse.)		
1. Obtain:		
a) a yellow nylon laundry bag	____	____
b) yellow canvas outer bag	____	____
c) 2 plastic garbage bags	____	____
d) 2 plastic garbage containers	____	____
2. Set scene by:		
a) placing nylon laundry bag into garbage container in room	____	____
b) placing plastic garbage bag into second garbage container in room	____	____
c) identifying self as "contaminated" nurse and partner as "clean" nurse	____	____
d) standing just inside doorway	____	____
e) asking partner to stand just outside	____	____
Contaminated Nurse:		
3. Close top of nylon laundry bag securely.	____	____
4. Place bag in cuffed canvas bag opened by nurse outside doorway.	____	____
5. Repeat using plastic garbage bags.	____	____

	Satisf. +	Unsatis. -
Clean Nurse:		
6. Place hands under cuff and open as wide as possible.	______	______
7. After bag is placed inside, secure the bag, touching only outside of bag.	______	______
8. Repeat using plastic garbage bags.	______	______
REMOVING GLOVES: (If gown is worn, untie waist ties first.)		
1. Remove first glove by grasping just below cuff.	______	______
2. Pull first glove off so it is inside out in gloved hand.	______	______
3. Place 2 fingers of your bare hand inside the cuff of second glove.	______	______
4. Pull second glove off by turning inside out (first glove will be inside).	______	______
5. Discard gloves.	______	______
6. Wash your hands.	______	______
REMOVING A SOILED GOWN:		
1. Avoid touching the outside of the gown with bare hands.	______	______
2. Roll up gown with soiled part inside.	______	______
3. Discard in appropriate container.	______	______
4. Wash hands.	______	______
REMOVING A FACE MASK:		
1. Remove and discard face mask.	______	______
2. Wash hands.	______	______

Comments:

(   ) Pass   (   ) Fail

________________________________   ________________

Instructor's Signature   Date

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills I Packet

Assignment Sheet

CAREGIVER ROLE
Unit: Fluids and Nutrition

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
The student will explain the principles of properly feeding the patient.	Read Kozier pgs. 337-339 View MED 323 "Feeding the Patient" (14 min)		Pass Written Quiz/Worksheet

Unit: Antiemboli Stockings, Bandages and Binders

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
The student will demonstrate competency in applying: 1) TEDS 2) ace bandage.	Read Kozier pgs. 549-551, 574-581	Instructor Demo	Self-checkoff

Unit: Heat and Cold

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in applying warm, moist packs (nonsterile) with aquathermia pad (K Pad)	Read Kozier pgs. 587-589 597-599	Practice Skill	Pass Performance Test

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills I Packet
Performance Test

UNIT: HEAT AND COLD

Applying Warm Moist Packs (Unsterile) with Aquathermia Pad

	Satis. +	Unsatis. -
1. Verify order.		
2. Wash your hands.		
3. Assemble equipment: a) aquathermia pad (K-Pad) filled with distilled water and set at 105°F b) cover for pad c) one bath towel d) plastic: approximately the width of area to be covered e) masking tape f) bath thermometer		
4. Identify patient.		
5. Explain the procedure.		
6. Screen for privacy, raise the bed to working level.		
7. Turn on K-Pad Unit. Check water level, loosen cap 1/4 turn and place cover on pad. (May use pillow case or disposable cover.)		
8. Place K-pad on bed under affected area.		
9. Place piece of plastic on top of K-Pad.		
10. Obtain water 105°-115°F in bath basin.		
11. Moisten towel and wring out excess water.		
12. Touch portion of towel to skin surface to check temperature.		
13. Place towel over body part, molding to skin surface.		
14. Immediately wrap plastic over towel.		
15. Then wrap K-Pad snugly around the towel and plastic and hold in place with masking tape.		
16. Lower bed.		
17. Check to make sure that unit, K-pad and tubing are at approximately the same level.		

	Satis. +	**Unsatis.** -
18. Chart procedure.	______	______
19. Recheck every one-two hours.	______	______

Comments:

_____ Pass _____ Fail

______________________________ Instructor's signature

__________________ Date

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EXHIBIT G

Nursing Skills II

Associate Degree Nursing Program

Chippewa Valley Technical College

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing - Technical Program

COURSE SYLLABUS

COURSE: Nursing Skills II

COURSE NUMBER: 510-114 CREDITS: 1

PREREQUISITES: Completion of or concurrent enrollment in 510-110 Introduction to Nursing and 510-101 Nursing Skills I.
Challenge option for LPNs.

COURSE LEAD: Sonja Rathbun

RESOURCES:

Kozier, Barbara & Erb, Genora, Techniques in Clinical Nursing, 3rd Edition, Addison-Wesley, 1989.

Kozier, Erb, and Bufalino, Introduction to Nursing, 1st Edition, Addison-Wesley, 1988.

Lippincott Learning System, Fundamental Nursing Skills, J. B. Lippincott Co., Philadelphia-Toronto.

Nursing Skills II packet

COURSE DESCRIPTION:

This competency-based course includes the demonstration or development of more advanced motor skills involving sterile technique, administration of medication, dressing changes, treatments, irrigations, handling hazardous waste and care of healthy infants. Skills are developed through a variety of methods designed for self-directed learning activities as outlined in individual learning packets and evaluated by faculty for competence. This course may be completed before or concurrently with 510-150 Intermediate Nursing and 510-151 Intermediate Nursing Practice I.

METHODS OF INSTRUCTION:

Competency-based instruction
Textbook assignments and/or handouts
Laboratory displaysLaboratory practice
Audiovisual materials
Instructor demonstrations

METHODS OF EVALUATION:

Performance Tests, Self-Checkoffs, Computer Quizzes

USE OF SKILLS LAB:

The lab will be open and staffed by at least one instructor Monday through Friday, 8:00 a.m.-4:00 p.m. Hours after 4:00 p.m. will be posted.

Viewing of audiovisuals may be done in the library, in the Phillips AV room (P109) or in the skills lab. Headsets are required in the lab so as not to disturb others.

You may practice for your performance tests at any time. To insure that a bed is available for your practice, you may sign up ahead for "independent practice". If you desire instructor assistance, you may sign up for "supervised practice".

When you are ready to take your performance test, you will sign the "performance test" schedule. If unable to keep your appointment, notify instructor as soon as possible.

The equipment you will need will be in labeled cupboards. Your cooperation is expected in putting equipment away and always leaving the lab as you found it.

The lab instructor will be available to answer questions if she is not scheduled for a performance test or supervised practice.

Instructor demonstrations will be posted on Monday morning for each week, so check the bulletin board. They will usually be scheduled twice. You will be accountable for information given at each instructor demonstration.

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ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills II Packet

Student Performance Record

Performance Tests:	1st Attempt	2nd Attempt	3rd Attempt
1. Donning and Removing Sterile Gloves			
2. Handling Sterile Supplies			
3. Changing a Sterile Dressing			
4. Irrigating a Wound			
5. Deep Breathing, Coughing and Leg Exercises			
6. Assessing Bowel Sounds			
7. Administering Oxygen (cannula and mask)			
8. Oropharyngeal Suctioning			
9. Taking Apical Pulse and Identifying Pulse Points			
10. Preparing and Administering Oral Medications			
11. Parenteral Medication: Sites and Methods of Injection			
12. Parenteral Medication: Mixing Two Medications, Withdrawing from a Vial, Administering a Sub-cu			
13. Parenteral Medication: Preparing a Tubex, Administering an IM			
14. Parenteral Medication: Removing Medication from an Ampule, Administering a Z-track Injection			
15. Catheterization: Male, Straight Catheter			
16. Catheterization: Female, Retention Catheter			
17. Catheter Irrigation: Open Method			
18. Obtaining a Sterile Urine Specimen from Retention Catheter			

Performance Tests:	1st Attempt	2nd Attempt	3rd Attempt
19. Removing a Retention Catheter	______	______	______
20. Collecting a Urine Specimen: Clean Catch	______	______	______
21. Colostomy Irrigation	______	______	______
22. Bathing Infant	______	______	______
23. Taking Infant's Temperature and Apical Pulse	______	______	______

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills II Packet

Student Performance Record

Instructor Demos

1. Changing a Sterile Dressing
2. Oropharyngeal Suctioning
3. Preparing and Administering Oral Medications
4. Catheterization: Female, Retention Catheter
5. Application of Urostomy Appliance
6. Care of Healthy Infants

Self-Checkoffs

1. ________ Measuring Blood Glucose
2. ________ Application of Urostomy Appliance

Peer Checkoffs

1. ________ Holding an Infant
2. ________ Cord Care and Diaper Change--Infant
3. ________ Burping and Positioning Baby

Computer Quizzes

1. ________ Asepsis and Wound Care
2. ________ Oral and Parenteral Medications
3. ________ Urine Elimination

Worksheet

1. ________ Syringes and Needles

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills II Packet

ASSIGNMENT SHEET

CAREGIVER ROLE
UNIT: ASEPSIS

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in donning and removing sterile gloves - open gloving technique.	Read Kozier & Erb "Techniques in Clinical Nursing" pgs. 48-50 View MED 321 "Sterile Technique" (16 min.) View MED 101 "Open Gloving" (14 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in handling sterile supplies.	Read Kozier pgs. 42-48 View MED 104 "Sterile Supplies" (19 min.)	Practice Skill	Pass Performance Test

UNIT: WOUND CARE

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will explain the principles of applying binders.	Read Kozier pgs. 567-573 View MED 163 "Bandages and Binders"		
Student will demonstrate competency in changing a sterile dressing.	Read Kozier pgs. 603-609, 612-615 View MED 159 Dressing Change--Draining" (16 min.)	Instructor Demo Practice Skill	Pass Performance Test
Student will demonstrate competency in irrigating a wound.	Read Kozier, pgs. 620-621 View MED 160 "Wound Irrigation" (12 min.)	Practice Skill	Pass Performance Test

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will explain the principles of use of drains and suction apparatus.	Read Kozier pgs. 621-623		
Student will identify the rationale for skills learned in asepsis and wound care.	Review Learning Activities for asepsis and wound care		Take Computer Quiz

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ASEPSIS

Donning and Removing Sterile Gloves

	Satis. +	Unsat. -
1. Wash your hands.	____	____
2. Open package of sterile gloves and remove inner wrapper.	____	____
3. Discard or set aside outer wrapper.	____	____
4. Unfold inner wrapper, touching only the corners.	____	____
5. Open wrapper to expose gloves, touching only folded back edges.	____	____
6. Grasp cuff of first glove, touching only inner surface of glove.	____	____
7. Lift glove twelve to eighteen inches above the table.	____	____
8. Insert other hand into glove.	____	____
9. Slip fingers of gloved hand under cuff of second glove.	____	____
10. Lift second glove up from folder.	____	____
11. Insert other hand into second glove, keeping gloved thumb away from the palm.	____	____
To Remove		
12. With either hand grasp outside of opposite glove at wrist.	____	____
13. Strip off glove inside out.	____	____
14. Crumple glove with gloved fingers.	____	____
15. Insert bare fingers under cuff of remaining glove, grasping it from the inside.	____	____
16. Strip off glove inside out with other glove enclosed.	____	____
17. Lay gloves on open wrapper; close wrapper.	____	____
18. Discard gloves and wrapper.	____	____
19. Wash your hands.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ASEPSIS

Handling Sterile Supplies

	Satis. +	Unsat. -
Opening a Sterile Tray		
1. Wash your hands.	____	____
2. Assemble equipment. a) sterile dressing set b) sterile peel-back wrapper c) bottle of sterile solution	____	____
3. Remove plastic wrapper from sterile set provided in lab.	____	____
4. Position tray so outer flap will open away from you.	____	____
5. Open outer flap, touching only the outside.	____	____
6. Open right flap with right hand.	____	____
7. Open left flap with left hand.	____	____
8. Pick up forceps under last flap (if part of sterile set) and place on edge of sterile field, with handle end on unsterile edge.	____	____
9. Then open last flap toward self.	____	____
10. Verbally identify area of sterile field	____	____
Opening Commercially Prepared Packages		
11. Obtain package of sterile supplies in peel-back wrapper.	____	____
12. Grasp both sides of the edge, one with each hand, and pull apart gently; hold package 6 inches above field and drop contents on sterile field. (Remember, one inch border is unsterile.)	____	____
Adding Sterile Solution to Sterile Field		
13. With forceps set medicine cup upright on sterile field near edge	____	____
14. Remove cap from bottle of sterile solution without touching rim.	____	____
15. Place cap on table without contaminating rim.	____	____
16. Pour solution into medicine cup and away from the label.	____	____
17. Replace cap.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: WOUND CARE

Changing a Sterile Dressing

		Satis. +	Unsat. -
1.	Verify doctor's order.	_____	_____
2.	Wash your hands.	_____	_____
3.	Assemble equipment.	_____	_____
	a) exam gloves b) plastic bag and tie c) 2 packages betadine swabs d) 2 telfa pads e) 1 precut gauze square f) 2 gauze squares g) 2 fluffs h) 1 surgipad i) tape		
4.	Identify patient.	_____	_____
5.	Explain the procedure.	_____	_____
6.	Screen for privacy.	_____	_____
7.	Raise the bed to working height.	_____	_____
8.	Lower side rail on NEAR side.	_____	_____
9.	Assist patient to a comfortable position.	_____	_____
10.	Expose wound area; use bath blanket to cover the patient, if necessary.	_____	_____
11.	Open sterile dressing set on tray table.	_____	_____
12.	Cuff plastic bag and place on bed within reach.	_____	_____
13.	Add extra supplies, if needed.	_____	_____
14.	Untie montgomery strap ties, if used.	_____	_____
15.	If tape was used, remove by holding down skin and pulling tape toward incision.	_____	_____
16.	Either don gloves (nonsterile) or use forceps to remove soiled dressings.	_____	_____
17.	Note drainage (color, odor, amount, consistency) and then place in plastic bag.	_____	_____
18.	Dispose of forceps or gloves in plastic bag.	_____	_____

		Satis. +	Unsat. -
19.	Open package of cleansing swabs.		
20.	Warn patient that solution will feel cold.		
21.	Cleanse directly over incision from top to bottom; discard swab.		
22.	With second swab, cleanse down on far side of incision.		
23.	With third swab, cleanse down near side of incision; discard swab.		
24.	If drain is present, take swabs from second package and cleanse around drain site.		
25.	Apply sterile dressings over incision, using forceps or sterile gloves.		
26.	Place pre-cut gauze square around drain site.		
27.	Place additional dressings over drain.		
28.	Cover dressings with surgipad.		
29.	Remove sterile gloves and dispose.		
30.	Secure dressing with tape or montgomery strap ties.		
31.	Seal plastic disposal bag and discard.		
32.	Make patient comfortable; replace covers.		
33.	Raise side rail and lower bed.		
34.	Wash hands.		
35.	Record procedure: a) appearance of wound and drainage. b) how the patient tolerated procedure.		

Comments:

_____ Satisfactory _____ Unsatisfactory

Instructor ____________________ Date ____________________

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: WOUND CARE
Irrigating a Wound

	Satis. +	Unsat. -
1. Verify doctor's order.	____	____
2. Wash your hands.	____	____
3. Assemble equipment. a) irrigation set b) irrigating solution c) sterile 4 X 4 d) chux pad	____	____
4. Identify patient.	____	____
5. Explain the procedure.	____	____
6. Screen for privacy.	____	____
7. Raise the bed to working height.	____	____
8. Lower side rail on NEAR side.	____	____
9. Assist patient into position so that irrigating solution will flow into basin.	____	____
(For this test, dressing will be removed previously.)		
10. Place blue pad beneath incision to absorb drainage.	____	____
11. Open sterile irrigating set on tray table.	____	____
12. Remove irrigating container and stand upright.	____	____
13. Remove cap from irrigating solution and set down with rim up.	____	____
14. Hold bulb syringe and cover in one hand and pour approximately 300 cc irrigating solution into container and replace cover.	____	____
15. Replace cap on solution bottle.	____	____
16. Fill syringe touching only end of plunger.	____	____
17. Hold drainage basin snugly next to skin beneath incision until irrigation is completed.	____	____
18. Gently instill a steady stream of irrigating solution over the wound.	____	____
19. Continue irrigating until the solution becomes clear.	____	____
20. Using sterile 4 X 4, dry the area around the wound.	____	____
21. Record the procedure: a) amount and kind of solution used b) appearance of irrigation returns	____	____

NOTE: Because of the previous performance test "Changing A Sterile Dressing" we will not apply a dressing.

Comments:

_____ Satisfactory _____ Unsatisfactory

____ Instructor

____________________ Date

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ASSIGNMENT SHEET

CAREGIVER ROLE

UNIT: PERIOPERATIVE CARE

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in deep-breathing exercises, coughing and leg exercises.	Read Kozier, pgs. 544-547 View MED 91 "Chest Therapy: Cough and Deep Breathe" (20 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in assessing bowel sounds.	Read Kozier Introduction to Nursing, pg. 470-471 (text in lab)	Practice Skill	Pass Performance Test

UNIT: OXYGENATION

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in administering oxygen.	Read Kozier, pgs. 657-667 View MED 89 "Oxygen Therapy Practice" (12 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in pharyngeal suctioning.	Read Kozier, pgs. 650-654	Instructor Demo Practice Skill	Pass Performance Test

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CHIPPEWA VALLEY TECHNICAL COLLEGE
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ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: PERIOPERATIVE CARE

Preop Teaching: Deep-Breathing Exercises, Coughing and Leg Exercises

Instructions: Bring a partner to be your patient.

	Satis. +	Unsat. -
1. Wash your hands.	____	____
2. Identify patient.	____	____
3. Explain the procedure.	____	____
4. Screen for privacy.	____	____
5. Raise bed to working height.	____	____
Deep Breathing Exercise (Diaphragmatic and Pursed Lip)		
6. Lie on back of semi-Fowler's position.	____	____
7. Place one hand on chest and one hand on abdomen.	____	____
8. Exhale and then...	____	____
9. Inhale deeply through nose, concentrate on abdomen rising.	____	____
10. Hold your breath and count to 5.	____	____
11. Purse lips and exhale completely through mouth.	____	____
12. Use the abdominal muscles to squeeze all the air out.	____	____
13. Splint the incision with a pillow prn.	____	____
14. Repeat 5 to 10 times.	____	____
Coughing		
15. Take 2 deep breaths.	____	____
16. On third breath inhale, hold, then cough vigorously on expiration.	____	____
17. Repeat 2-3 times.	____	____
18. Splint the incision with a pillow PRN.	____	____

Leg Exercises	Satis. +	Unsat. -
19. Point toes toward the foot of the bed.	____	____
20. Point toes up.	____	____
21. Make a circle with your toes.	____	____
22. Raise one leg off the bed and bring your knee up toward your chest.	____	____
23. As you lower leg, extend it and point toes toward foot of bed.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: PERIOPERATIVE CARE
Assessing Bowel Sounds

Instructions: Bring a partner to be your patient.

	Satis. **+**	**Unsat.** **-**
1. Wash your hands.	____	____
2. Bring stethoscope.	____	____
3. Identify patient.	____	____
4. Explain the procedure.	____	____
5. Screen for privacy.	____	____
6. Raise bed to working height; lower rail on NEAR side.	____	____
7. Place the patient in the supine position.	____	____
8. Expose the patient's abdomen from chest to the pubic area.	____	____
9. Inspect the abdomen for distention, incision, dressings, drains.	____	____
10. Place the flat diaphragm of the stethoscope on all four quadrants of the abdomen.	____	____
11. Listen for active bowel sounds. **NOTE:** If bowel sounds appear to be absent, listen for 3 to 5 minutes before concluding that they are absent.	____	____
12. Palpate abdomen, checking for softness or distention.	____	____
13. Replace covers, raise side rail, lower bed.	____	____
14. Record results.	____	____

Terms used for charting:
- a) Normal bowel sounds are audible.
- b) Soft or infrequent bowel sounds are hypoactive.
- c) Loud, frequent rushing sounds are hyperactive.

Comments:

_____ Satisfactory _____ Unsatisfactory

______________________________ Instructor

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
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Name ____________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: OXYGEN THERAPY
Administering Oxygen

		Satis. +	Unsat. -
1.	Verify physician order.	____	____
2.	Wash your hands.	____	____
3.	Assemble equipment. a) nasal cannula and simple mask b) bubble humidifier c) connecting tubing d) flow meter e) sterile water or normal saline	____	____
4.	Identify patient.	____	____
5.	Explain purpose, procedure and safety precautions to patient.	____	____
6.	Fill humidifier with sterile water.	____	____
7.	Connect flowmeter.	____	____
8.	Insert unit into wall outlet (verbalize)	____	____
9.	Attach nasal cannula tubing to connecting humidifier.	____	____
10.	Turn flowmeter to prescribed setting.	____	____
11.	Place the nasal prongs into the patient's nostrils.	____	____
12.	Place tubing over ears.	____	____
13.	Check flow rate of oxygen.	____	____
14.	Change nasal cannula to simple face mask.	____	____
15.	Place face mask on patient.	____	____
16.	Adjust straps.	____	____
17.	Check flow rate.	____	____
18.	Record	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

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Name ______________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: AERATION AND OXYGENATION

Oropharyngeal Suctioning

	Satis. +	Unsat. -
1. Verify doctor's order.		
2. Wash your hands.		
3. Assemble equipment. a) portable suction machine b) sterile suction catheter set c) sterile glove d) cup or container e) sterile water or normal saline f) plastic bag g) towel		
4. Identify patient.		
5. Explain the procedure.		
6. Screen for privacy.		
7. Raise bed to working height.		
8. Lower side rail on NEAR side.		
9. Position patient: a) semi-Fowler's, head to side if conscious		
b) lateral if unconscious		
10. Place towel under chin or over the pillow.		
11. Set pressure according to institutional policy, turn on suction.		
12. Open sterile suction catheter set: a) set up cup or container b) pour sterile solution into container c) don the sterile glove on dominant hand		
13. With sterile gloved hand, pick up catheter and attach to suction unit.		
14. Moisten catheter tip by dipping in sterile solution.		
15. Test the suction by applying your thumb to the port (suction control) to create suction.		
16. Insert catheter through mouth into oropharynx without applying suction.		

		Satis. +	Unsat. -
17.	Apply thumb to suction control port and gently rotate catheter.	_____	_____
18.	Apply suction for 5-10 seconds, then stop and remove catheter.	_____	_____
19.	Flush catheter with sterile solution and repeat.	_____	_____
20.	Encourage patient to cough and deep breathe between suctions.	_____	_____
21.	Assist patient with oral hygiene (verbalize).	_____	_____
22.	Reposition patient; raise side rail, lower bed.	_____	_____
23.	Dispose of equipment.	_____	_____
24.	Document: a) amount of sputum. b) color of sputum. c) odor of sputum. d) consistency of sputum.	_____	_____

Comments:

_____ Satisfactory _____ Unsatisfactory

______________________________ ____________________
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Nursing Skills II Packet

ASSIGNMENT SHEET

CAREGIVER ROLE
UNIT: VITAL SIGNS

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in taking an apical pulse and identifying pulse points.	Read Kozier pgs. 71-79 View MED 327 "The Doppler Ultrasound Stethoscope" (16 min.)	Practice Skills using stethoscope and doppler	Pass Performance Test

UNIT: SPECIMEN COLLECTION

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in measuring blood glucose.	Read Kozier pgs. 115-116 Listen to "One-Step" instruction tape (Skills Lab)	Practice Skill (Procedure is with "one-step" glucometer)	Self-Checkoff

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: VITAL SIGNS
Taking an Apical Pulse and Identifying Pulse Points

Instructions: Bring a partner to be your patient.	Satis. +	Unsatis. -
1. Wash your hands.	____	____
2. Assemble equipment: a) stethoscope b) alcohol wipe c) watch with second hand	____	____
3. Identify patient.	____	____
4. Explain the procedure.	____	____
5. Screen for privacy.	____	____
Apical Pulse		
6. Warm diaphragm of stethoscope.	____	____
7. Place diaphragm over apex of heart (L. 5th intercostal space, below nipple line)	____	____
8. Listen for heart sounds ("lub dub").	____	____
9. Count beats for one full minute.	____	____
10. Note rate, rhythm, strength of heartbeat.	____	____
11. Record.	____	____
12. Wipe diaphragm and earpieces with alcohol wipe.	____	____
Pulse Points		
1. Identify each of the following pulse points:		
a) temporal	____	____
b) carotid	____	____
c) brachial	____	____
d) radial	____	____
e) femoral	____	____
f) popliteal	____	____
g) posterior tibial	____	____
h) dorsalis pedis (pedal pulse)	____	____

Comments:

____ Pass ____ Fail

______________________________ Instructor's signature

______________________________ Date

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Nursing Skills II Packet

ASSIGNMENT SHEET

CAREGIVER ROLE
UNIT: MEDICATIONS

OBJECTIVE	ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in preparing and administering oral medications.	Read Kozier pgs. 481-489 View MED 180 "Equipment and Supplies" (14 min.) View MED 181 "Preparation and Practice" (20 min.) View MED 182 "Administration" (9 min.) View MED 318 "Basic Clinical Skills: Adm., Oral, Topical, Supp. and Inhal. Meds" (25 min.)	Instructor Demo Practice Skill	Pass Performance Test
Student will identify parts of a syringe and needle.	Read Kozier pgs. 506-508 View MED 183 "Equipment: Syringes and Needles" (28 min.) View MED 184 "Handling A Sterile Syringe and Needle" (15 min.)	Lab Display	Complete "Syringes and Needles" Worksheet
Student will identify sites and methods used for administering subcutaneous, intramuscular and intradermal injections. Medications Unit	Read Kozier pgs. 513-525, View MED 187 "Sites & Methods of of Injection" (30 min.)	Practice Skill	Pass Performance Test

Nursing Skills II Packet
Medications Assignment Sheet

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
	View MED 319 "Basic Clinical Skills: Adm IM, SQ and Intradermal Injections (25 min.)		
Student will demonstrate competency in mixing two medications, withdrawing medication from a vial and administering a subcutaneous injection.	Read Kozier pgs. 508-517 View MED 185 "Removal of Medication from a Vial" (10 min.) View MED 188 "Adm. of Subq Injection" (12 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in preparing a tubex holder and cartridge and administering an intramuscular injection.	Read Kozier pgs. 507, 517-523 View MED 189 "Adm. of I.M. Injection" (14 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in removing medication from an ampule and administering a Z-track injection.	Read Kozier pgs. 508-511, 523-524 View MED 186 "Removal of Med from an Ampule" (10 min.) View MED 190 "Prevention of Tracking" (12 min.)	Practice Skill	Pass Performance Test
Student will identify the rationale for skills learned in Medications Unit.	Review learning activities for Medications Unit		Take Computer Quiz

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COMMONLY USED ABBREVIATIONS

You will need to know these before administering medications.

Abbreviation	Meaning
aa	of each
abd.	abdomen
a.c.	before meals
ad lib.	as needed
A.M.	morning
amb.	ambulatory, walking
amt.	amount
approx.	approximately (about)
ax.	axillary (armpit)
b.i.d.	twice per day
BMR	basal metabolic rate
BM	bowel movement
BP	blood pressure
BRP	bathroom privileges
C	centigrade
c	with
ca	cancer
cc (c.c.)	cubic centimeters
cmpd.	compound
c/o	complains of
DC	discontinue
dist.	distilled
dr	dram (measurement)
ECG (EKG)	electrocardiogram (tracing of heart function)
EEG	electroencephalogram (brain wave tracing)
ER	emergency room
elix.	elixir
exam	examination
ext.	extract
F	Fahrenheit
Fe	iron
fld.	fluid
GI	gastrointestinal (stomach and intestinal)
gm	gram (measurement)
gr	grain (measurement)
gtt (sig.-gt)	drops (measurement)
GU	genitourinary (pertaining to organs of reproduction and urinary excretion)
h	hour
hi-cal	high calorie
hi-vit	high vitamin
Hgb	hemoglobin
H_2O	water
h.s.	bedtime (hour of sleep)
invol.	involuntary (without knowledge of)
irrig.	irrigate
I & O	intake and output
IV	intravenous (within vein

Abbreviation	Meaning
kg.	kilogram (weight)
lab.	laboratory
lb	pound
liq.	liquid
LLQ	left lower quadrant (left lower section of abdomen)
LUQ	left upper quadrant
M	minim (measurement)
med.	medical (or medication)
mid.	middle
min.	minute
mg	milligram (measurement)
no.	number
noc.	night
NPO	nothing by mouth (nulli per os)
O_2	oxygen
OB	obstetrics
OR	operating room
O.D.	right eye
O.U.	each eye
O.S.	left eye
oz	ounce
P	pulse
Ped. or Peds, or Pedi	pediatrics
per	by or through
p.o.	per os. or by mouth
post-op	postoperative (after surgery)
p.r.n.	when necessary
pre-op	preoperative (before surgery)
pt.	patient
PT	physical Therapist
q.d.	every day
q.h.	every hour
q.i.d.	four times per day
q.o.d.	every other day
q.s.	quantity sufficient
R or resp.	respirations
RBC	red blood cells
RLQ	right lower quadrant (right lower quarter of abdomen)
RUQ	right upper quadrant of abdomen
s	without
sol.	solution
sp. gr.	specific gravity (measure)
SS	soapsuds
ss	one-half
stat.	at once
staph	staphylococcus (germ)
tab	tablet
t.i.d.	three times a day
TPR	temperature, pulse, respiration
VD	veneral disease
via	by way of
WBC	white blood cell
wt.	weight

NUMBERS AND SYMBOLS COMMONLY USED IN CHARTING

One

Two

Three

Four

Five v

Six vi

Seven v
ii

Eight viii

Nine ix

Ten x

Eleven xi

Twelve xii and etc.

And et, + &

greater than

less than

dram

ounce

grain gr

one-half ss

one and one-half iss

three ounces iii

two drams ii

number #, no.

with c

without s

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: MEDICATIONS

Oral Medication Preparation and Administration

Administer all 0900 medications.

	Satis. +	Unsatis. -
Preparation		
1. Wash hands.	______	______
2. Assemble equipment. a) med cart b) Medication Administration Record (MAR) c) medication cups	______	______
3. Check date on medication order and verify for accuracy.	______	______
4. Read Medication Administration Record (MAR) and take appropriate medication from drawer.	______	______
5. Compare medication with MAR. **(Check #1)** (5 rights - verbalize)	______	______
6. Prepare correct amount for required dose without touching medications. (Check labels with MAR, **Check #2.**)	______	______

Multi-dose Containers

a) When administering tablets or capsules, pour required number into bottle cap and then transfer to paper cup. (Use separate cup for medications that must remain identified.)

Unit-dose

b) Place unit-dose medications in paper cup. (DO NOT OPEN PACKAGE.)

Liquids Over 5cc

c) When pouring liquid medications, pour away from label. Hold cup at eye level and fill to desired level using bottom of meniscus as measurement guide.

Liquids Less than 5cc

d) Hold medicine dropper at right angle to plastic medicine cup while measuring drops. (Add water to very small doses of liquids.)

	Satis. +	Unsatis. -
7. Place medication on tray.	______	______
8. Check labels with MAR again **(Check #3)**.	______	______

	Satis. +	Unsatis. -
Administration		
9. Identify patient by comparing name on MAR to name on ID bracelet and by asking patient to state name.	_____	_____
10. Open unit dose medications and place in paper cup.	_____	_____
11. Explain the purpose of medication.	_____	_____
12. Assist the patient to sitting, or if not possible, to a lateral position.	_____	_____
13. Take required assessment measures.	_____	_____
14. If appropriate, give client sufficient water or juice to swallow medication.	_____	_____
15. Stay with patient until medications have been swallowed.	_____	_____
16. Record medication given using 5 rights.	_____	_____

Comments:

_____ Pass _____ Fail

______________________________ ________________
Instructor's signature Date

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SYRINGES AND NEEDLES WORKSHEET

Items 1 through 5: Using the accompanying diagrams, label the parts of a syringe.

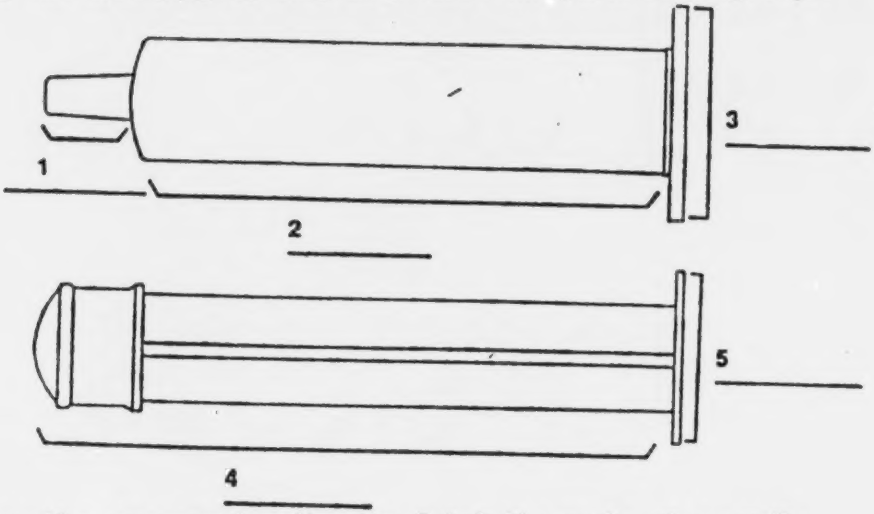
a. barrel

b. plunger

c. flange

d. tip

e. plunger end



Items 6 through 11: Using the accompanying diagram, label the parts of a needle.

a. point

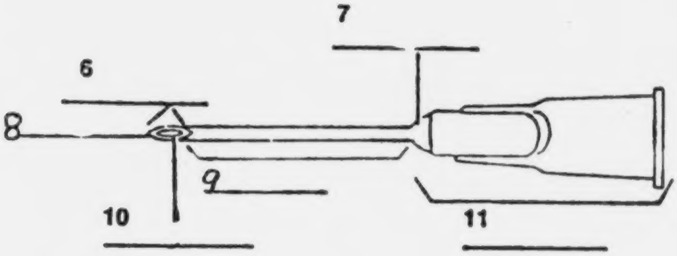
b. lumen

c. shaft

d. hilt

e. hub

ab. bevel



Items 12 through 19: Identify the amount of medication contained in each of the following syringes.

a. 5 units

b. 15 minims

c. 20 M

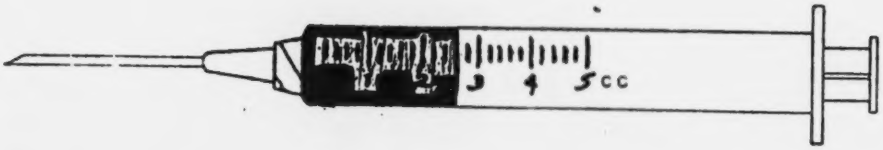
d. 1.4 cc

e. 1.6 cc

ab. 2.4 cc

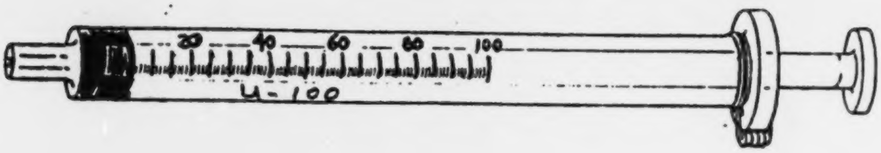
ac. 2.6 cc

ad. 30 U

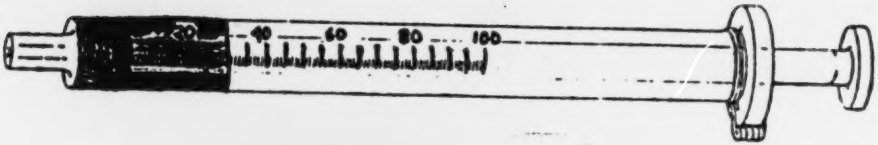


12. ____

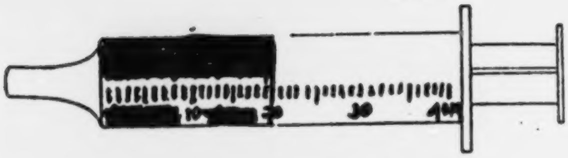
13. _____


20
40
60
80
100
U-100

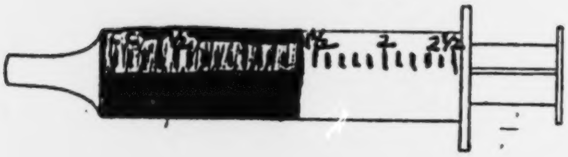
14. _____


20
40
60
80
100

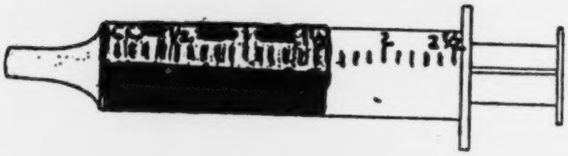
15. _____



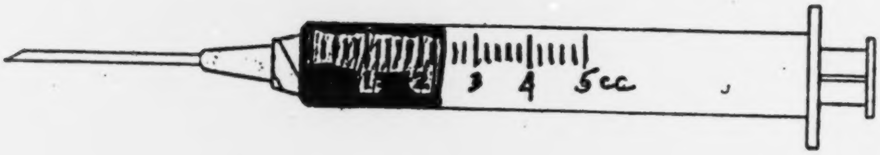
16. _____



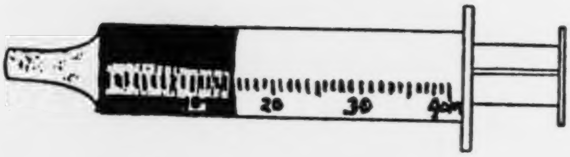
17. _____



18. _____



19. _____



Items 20 through 21: A = true, B = false

20. _____ When the plunger of a syringe is pulled away from the tip, the pressure inside the barrel is less than the pressure outside the barrel.

21. _____ To draw medication into the barrel of a syringe you should pull the plunger away from the tip.

Items 22 through 23: Select the needle you should use in the following situations.

a. 20 G needle

b. 25 G needle

22. _____ To give an aqueous medication

23. _____ To give a viscous medication

Items 24 through 25: Identify the following needle gauge number and shaft length for each needle shown below.

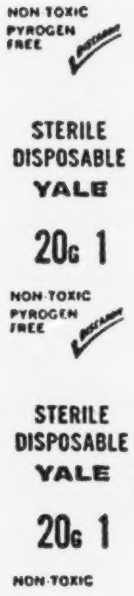
a. 25 G 1"

b. 25 G 5/8"

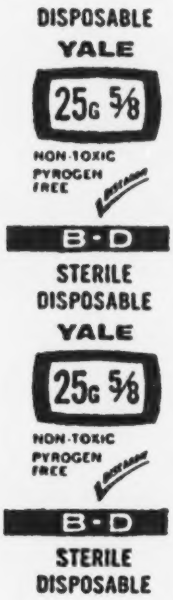
c. 20 G 1"

d. 20 G 1-1/2"

24. _____


NON·TOXIC
PYROGEN FREE
STERILE
DISPOSABLE
YALE
20G 1
NON·TOXIC
PYROGEN FREE
STERILE
DISPOSABLE
YALE
20G 1
NON·TOXIC

25. _____


DISPOSABLE
YALE
25G 5/8
NON·TOXIC
PYROGEN FREE
B-D
STERILE
DISPOSABLE
YALE
25G 5/8
NON·TOXIC
PYROGEN FREE
B-D
STERILE
DISPOSABLE

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: MEDICATIONS
Parenteral Medication: Sites and Methods of Injection

Instructions: Bring a partner to be your patient.

	Satis. +	Unsatis. -
1. Intradermal Injection		
Circumscribe the medial aspect of the anterior surface of the forearm approximately 2 inches below elbow and about 2 inches above wrist.	_____	_____
State syringe used is a TB syringe. Needle is 25 Gauge, 1/2 inch. Volume given usually 0.1cc. Angle used is 15 degree.	_____	_____
2. Subcutaneous Injection		
Circumscribe dorsilateral aspect of the upper arm approximately 3 to 5 inches above the elbow.	_____	_____
Circumscribe anterior and lateral aspect of thigh approximately 3 inches above knee.	_____	_____
Circumscribe area of abdomen avoiding belt line and about 1 inch around umbilicus.	_____	_____
State needle is 25 Gauge, 5/8 inch. Volume given is less than or equal to 2cc. Angle used is 45 degree. (Some institutions may use 1/2 inch needle at 90 degree angle.)	_____	_____
3. Intramuscular Injection		
Posterior gluteal site (dorsogluteal): Identify posterior superior iliac spine and greater trochanter; identify site by drawing an imaginary line connecting these structures.	_____	_____
Ventrogluteal site: Place palm over greater trochanter. Identify anterior superior iliac spine and iliac crest with index and middle fingers; identify site in triangle between fingers.	_____	_____
Vastus lateralis site: Circumscribe lateral aspect of vastus lateralis muscle by dividing the area between the greater trochanter and side of knee into thirds and identify site as middle third.	_____	_____
State needle is 20-22 gauge, 1 1/2-2 in. Volume is no greater than 3cc. Angle used is 90°.	_____	_____

	Satis. +	Unsatis. -
3. Intramuscular Injection (continued)		
Deltoid site: (No oil or irritating meds) Circumscribe area of deltoid muscle approximately 2 inches below acromial process and opposite axilla.	_____	_____
States needle is usually 22 Gauge, 1 inch. Volume given is less than or equal to 1 cc. Angle used is 90 degree.	_____	_____

Comments:

_____ Pass _____ Fail

_______________________________ _______________________
Instructor's signature Date

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Name ____________________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: MEDICATIONS

Parenteral Medication: Mixing Two Medications, Withdrawing Medications from a Vial and Administering a Subcutaneous Injection to a Model

Administer 0700 insulins from MAR (Medication Administration Record).

		Satis. +	Unsatis. -
A.	**Removing two medications from vials using one syringe.**		
1.	Wash hands.		
2.	Obtain and read medication order.		
3.	Assemble equipment.		
4.	State sources of information which validate that these two drugs may be mixed (when asked).		
5.	Compare MAR with doctor's order and check patient allergies.		
6.	Compare MAR with respective vial labels (5 rights--verbalize). **(Check #1)**		
7.	Rotate the vials between the palms of the hands to mix the solution.		
8.	Clean the tops of the vials with antiseptic swabs (one wipe).		
9.	Inject a volume of air equal to the volume of insulin to be withdrawn from Vial A (longer acting insulin).		
10.	Withdraw the needle from Vial A and inject the prescribed amount of air into Vial B (shorter acting insulin).		
11.	Withdraw the required amount of insulin from Vial B and compare to MAR for accuracy. **(Check #2)** Verify with R.N.		
12.	Withdraw the required amount of insulin from Vial A and compare to MAR for accuracy. **(Check #2)** Verify with R.N.		
13.	If too much of second medication is withdrawn, discard entire mixed mediction and begin again.		
14.	Replace needle sheath.		
15.	Place prepared syringe on tray with antiseptic swab.		

B. Administering a Subcutaneous Injection	**Satis.** +	**Unsatis.** -
16. Before taking medication into patient's room check accuracy of medication measurement (directly compare syringe, vials, and MAR.) **(Check #3)**		
17. Identify patient by a safe method, such as: using identification band, asking patient to state his name.		
18. Discuss the injection with the patient.		
19. Assist patient to an appropriate position.		
20. Identify the site for injection using appropriate anatomical guidelines: a) dorsilateral aspect of upper arms b) abdomen c) anterior and lateral aspects of thigh.		
21. Inspect and palpate the site for injection (rotate sites).		
22. Open an antiseptic swab.		
23. Check amount of medication in syringe.		
24. Remove needle sheath without contaminating the needle or plunger.		
25. Cleanse site using one stroke with the swab or circular motion, start at center and move outward.		
26. Pinch or spread skin at site depending on size of person.		
27. Rapidly insert needle at 45 to 90 degree angle (depending on size of person and length of needle).		
28. Draw back plunger to aspirate for blood while stablizing syringe.		
29. If blood is present in syringe, withdraw needle slightly; then aspirate again for blood.		
30. Inject medication slowly.		
31. Exert pressure against tissue with antiseptic swab while withdrawing needle.		
32. Do not massage area with insulin or heparin injections.		
33. Do not replace needle sheath, unless situation requires such action.		

	Satis. +	Unsatis. -
34. Assist patient to a comfortable position.	______	______
35. Remove equipment from patient's room and discard appropriately.	______	______
36. Record medication given using 5 rights.	______	______

Comments:

_____ Pass _____ Fail

______________________________ ________________
Instructor's signature Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
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Name ____________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: MEDICATIONS

Parenteral Medication: Preparing a Tubex Holder and Cartridge and Administering an Intramuscular Injection to a Model

A. Preparing a Tubex Holder and Cartridge	Satis. +	Unsatis. -
1. Wash hands.	______	______
2. Obtain and read medication order.	______	______
3. Assemble equipment.	______	______
4. Compare MAR with doctor's order and check patient allergies.	______	______
5. Compare MAR with tubex cartridge (5 rights--verbalize). **(Check #1)**	______	______
6. Calculate amount of medication to be administered.	______	______
7. Insert tubex cartridge into the tubex holder and remove needle sheath.	______	______
8. Remove air from cartridge (in upright position).	______	______
9. Tip tubex holder to side position and discard excess medication (if necessary).	______	______
10. Check accuracy of medication measurement by comparing MAR & tubex cartridge. **(Check #2)**	______	______
11. Add 0.2cc air bubble.	______	______
12. Replace needle sheath.	______	______
13. Place prepared syringe on tray with antiseptic wipe.	______	______
B. Administering an Intramuscular Injection		
14. Check accuracy of medication measurement (directly compare cartridge and MAR. **(Check #3)**	______	______
15. Identify patient by using the identification band.	______	______
16. Discuss the injection with the patient.	______	______
17. Assist patient to an appropriate position.	______	______
18. Identify the site for injection using appropriate anatomical guidelines:		
a) posterior gluteal site (dorsogluteal)	______	______
b) ventrogluteal site	______	______
c) vastus lateralis muscle	______	______
d) deltoid muscle	______	______

	Satis. +	Unsatis. -
19. Inspect and palpate the site for injection (rotate site).		
20. Open antiseptic swab.		
21. Check amount of medication and air in cartridge.		
22. Remove needle sheath without contaminating needle or plunger.		
23. Cleanse site using one stroke with the swab or circular motion (start at center and move outward).		
24. Draw tissue taut between thumb and index finger. (If emaciated, the muscle may be pinched.)		
25. Rapidly insert needle at a 90 degree angle (person of average size).		
26. Draw back on plunger to aspirate for blood while stabilizing syringe.		
27. If blood appears in syringe, withdraw needle a short distance and aspirate again.		
28. Inject medication slowly.		
29. Exert pressure against tissue with antiseptic swab while withdrawing needle.		
30. Massage area if absorption is to be hastened.		
31. Do not replace needle sheath - unless situation requires such action.		
32. Assist patient to a comfortable position.		
33. Remove equipment from patient's room and discard appropriately.		
34. Record medication given using 5 rights.		

Comments:

_____ Pass _____ Fail

______________________________ Instructor's signature

______________________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________

Nursing Skills II Packet
PERFORMANCE TEST

UNIT: MEDICATIONS

Parenteral Medication: Removing Medication from an Ampule and Administering a Z-track Injection

Administer 0900 Imferon from MAR (Medication Administration Record)

A. Removing medication from an ampule	**Satis.** +	**Unsatis.** -
1. Wash hands.	______	______
2. Obtain and read medication order.	______	______
3. Assemble equipment.	______	______
4. Compare MAR with doctor's orders and check patient allergies.	______	______
5. Assemble needle and syringe unit.	______	______
6. Compare MAR with ampule label. **(Check #1)** (verbalize 5 rights)	______	______
7. Calculate amount of medication to be withdrawn.	______	______
8. Snap finger against ampule neck to remove trapped liquid (if necessary).	______	______
9. Place swab or wrapping around top of ampule to break off neck; break in direction away from face.	______	______
10. Remove needle and sheath and replace with filter needle and sheath (if institutional policy indicates).	______	______
11. Pick up ampule between thumb and index finger and insert needle into slightly tipped ampule.	______	______
12. Withdraw exact amount of medication.	______	______
13. Remove needle from ampule. May change needle if medication is irritating or filter needle was used.	______	______
14. Remove all air bubbles from syringe without contaminating needle, needle hub, or syringe.	______	______
15. Check accuracy of medication measurement with MAR and ampule label. **(Check #2)**	______	______
16. Add 0.5 cc of air (only for Z-track method).	______	______
17. Replace needle sheath.	______	______
18. Place syringe and antiseptic swab on tray.	______	______

B. Administering a Z-track injection	**Satis.**	**Unsatis.**
+ -		
19. Before taking medication into patient's room check accuracy of medication measurement (directly compare syringe, ampule and MAR. **(Check #3)**		
20. Identify patient by using the identification band.		
21. Discuss the injection with the patient.		
22. Assist patient to an appropriate position.		
23. Identify site used for Z-track (only posterior gluteal site).		
24. Inspect and palpate the site for injection (rotate sites).		
25. Open antiseptic swab.		
26. Check amount of medication in syringe.		
27. Remove needle sheath without contaminating the needle or plunger.		
28. Cleanse site using one stroke with the swab or circular motion. (Start at center and move outward.)		
29. Displace the skin firmly prior to injection. Keep hand in this position until needle is withdrawn (to prevent tracking or the needle bending).		
30. Insert needle at 90 degree angle (person of average size).		
31. Draw back on plunger to aspirate for blood while stabilizing the syringe.		
32. If blood apears in syringe, withdraw needle a short distance and aspirate again.		
33. Inject medication slowly.		
34. After injection, wait 10 seconds before quickly withdrawing needle.		
35. Immediately after withdrawing needle, allow laterally displaced skin to return to usual position.		
36. Do NOT massage site after injection.		
37. Instruct patient not to indulge in strenuous exercise, not to wear a tight girdle and not to rub the site.		

	Satis. +	Unsatis. -
38. Do not replace needle sheath unless situation requires such action.		
39. Assist patient to a comfortable position.		
40. Remove equipment from patient's room and discard appropriately.		
41. Record medication given using 5 rights.		

Comments:

____ Pass ____ Fail

Instructor's signature

Date

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EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills II Packet

ASSIGNMENT SHEET

CAREGIVER ROLE
UNIT: ELIMINATION

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency catheterizing a MALE using a straight catheter.	Read Kozier, pgs. 423-434 View MED 142 "Catheterization: Intro" (11 min.) View MED 143 "Catheterization: Equipment" (14 min.) View MED 144 "Catheterization Preparation" (8 min.) View MED 146 "Catheterization Male" (8 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency catheterizing a FEMALE using a retention catheter.	Read Kozier, pgs. 434-439 View MED 147 "Retention Catheter: Drainage Equipment" (11 min.) View MED 148 "Retention Catheter: Catheterization and Drainage" (15 min.)	Instructor Demo Practice Skill	Pass Performance Test
Student will demonstrate competency in performing catheter irrigation--open method.	Read Kozier, pgs. 442-447 View MED 149 "Retention Catheter: Irrigation Equipment" (19 min.) View MED 150 "Retention Catheter: Irrigation Practice" (15 min.)	Practice Skill	Pass Performance Test

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in obtaining a sterile urine specimen from retention catheter.	Read Kozier, pgs. 98-99	Practice Skill	Pass Performance Test
Student will demonstrate competency in removing a retention catheter.	Read Kozier, pgs 441-442	Practice Skill	Pass Performance Test
Student will demonstrate competency in collecting a urine specimen by clean catch.	Read Kozier, pgs. 93, 96-98 View MED 152 "Collecting a Urine Specimen" (15 min.)	Practice Skill	Pass Performance Test
Student will demonstrate competency in applying a urostomy appliance.	Read Kozier, pgs 472-477 View MED 157 "Urostomy Appliances" (12 min.)	Instructor Demo	Self-checkoff
Student will explain the principles of inserting a rectal suppository, rectal tube, and removing a fecal impaction.	Read Kozier, pgs 416-419, 502-503		
Student will demonstrate competency in irrigating a colostomy.	Read Kozier, pgs 462-472 View MED 320 "Ostomy Care" (18 min.)	Practice Skill	Pass Performance Test

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ELIMINATION
Catheterization: Male
Straight Catheter

	Satis. +	Unsatis. -
1. Verify doctor's order.	____	____
2. Wash your hands.	____	____
3. Assemble equipment: a) straight catheter set b) extra set of sterile gloves (optional).	____	____
4. Identify patient.	____	____
5. Explain the procedure.	____	____
6. Screen for privacy.	____	____
7. Raise the bed to working height.	____	____
8. Lower side rail on NEAR side.	____	____
9. Fold back top covers to expose penis and thighs.	____	____
10. Assist the patient to a supine position with knees slightly flexed, thighs slightly apart.	____	____
11. Place catheter set between patient's legs.	____	____
12. Remove and cuff plastic wrapper and set near foot of bed; use for disposal of equipment.	____	____
13. Open set following principles of asepsis.	____	____
14. Pick up first drape touching only the corners and place under penis (shiny side down).	____	____
15. Put on sterile gloves.	____	____
16. Pick up fenestrated drape, wrap around gloved hands and place over penis and pubic area, exposing only the penis.	____	____
17. Prepare equipment: a) saturate cotton balls with antiseptic solution b) open packet of lubricant and lubricate tip of catheter 3-4 inches.	____	____
18. Grasp penis just below glans; retract foreskin, if uncircumcised.	____	____
19. Using forceps, cleanse glans using circular motion from meatus outward.	____	____
20. Repeat twice.	____	____

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		Satis. +	Unsat. -
1.	Place the drainage end of catheter in the urine receptacle.	____	____
22.	Tell patient you will be inserting catheter.	____	____
23.	Pick up the insertion end about two inches from tip.____	____	
24.	Elevate penis perpendicular to the body.	____	____
25.	Insert catheter steadily about eight inches until urine begins to flow.	____	____
26.	If you meet with slight resistance try twisting the catheter or ask the patient to take deep breaths. DO NOT FORCE!	____	____
27.	Lower penis and hold catheter in place at the meatus.	____	____
28.	To collect a urine specimen: a) allow urine to flow for a few seconds b) pinch catheter and place in specimen container c) allow required amount to flow (usually 30 ml) d) pinch catheter and replace in urine receptacle.	____	____
29.	Allow the bladder to empty (limit the amount of urine drained to 1000 cc if policy indicates).	____	____
30.	Remove the catheter slowly in one smooth motion.	____	____
31.	Replace the foreskin if uncircumcised.	____	____
32.	Dry the penis with drapes.	____	____
33.	Reposition patient and raise side rail, lower bed.	____	____
34.	Dispose of equipment.	____	____
35.	Report and record: a) size of catheter b) how patient tolerated procedure c) color, odor, amount, consistency of urine d) label specimen and send to lab immediately.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

________________________________ Instructor

________________ Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________

Nursing Skills II Packet
Performance Test

UNIT: ELIMINATION

Catheterization: Female Retention Catheter

	Satis. +	Unsat. -
1. Verify doctor's order.		
2. Wash your hands.		
3. Assemble equipment a) retention catheter set b) disposable gloves (optional) c) extra set of sterile gloves (optional)		
4. Identify patient.		
5. Explain the procedure.		
6. Screen for privacy.		
7. Raise the bed to working height.		
8. Lower side rail on NEAR side.		
9. Assist the patient to a supine position with knees flexed, feet apart, hips externally rotated.		
10. Drape patient with bath blanket.		
11. Don disposable gloves (optional) and wash perineal area with soap and water. (verbalize)		
12. Adjust the light or have an assistant hold a flashlight to help visualize urinary meatus.		
13. Remove and cuff plastic wrapper and set near foot of bed; use for disposal of equipment.		
14. Place retention catheter set between patient's legs.		
15. Open set following principles of asepsis.		
16. Pick up first drape touching only the corners and place under patient's buttocks (shiny side down).		
17. Put on sterile gloves.		
18. Pick up fenestrated drape; wrap around gloved hands and place over perineal area. (optional)		
19. Prepare equipment: a) clamp drainage tube on drainage bag b) saturate cotton balls with antiseptic solution c) test balloon by injecting fluid; deflate and leave syringe attached to catheter d) open packet of lubricant and lubricate tip of catheter (2 inches)		

	Satis. +	Unsat. -
0. Separate the labia with non-dominant hand.	____	____
21. Cleanse down one side; discard cotton ball.	____	____
22. Cleanse down other side; discard cotton ball.	____	____
23. Cleanse down the middle, visualizing the urinary meatus.	____	____
24. Tell the patient you will be inserting catheter.	____	____
25. Insert catheter approximately 2 inches (urine will return when tip is in bladder).	____	____
26. Insert 1/2 inch more to be sure balloon is beyond neck of bladder.		________
27. Hold catheter in place with contaminated hand.	____	____
28. Inflate balloon.	____	____
29. Tug slightly on catheter to be sure it is secure.	____	____
30. With both hands, remove syringe from catheter.	____	____
31. Place catheter and tubing over leg and attach drainage bag to bed frame.	____	____
32. Obtain sterile specimen from drainage bag immediately, if needed.	____	____
33. Pat perineal area dry with drapes.	____	____
34. Reposition patient and raise side rail; lower bed.	____	____
35. Dispose of equipment.	____	____
36. Report and record: a) size of catheter and balloon b) how patient tolerated procedure c) color, odor, amount, consistency of urine	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ ______________________

Instructor Date

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ELIMINATION
Catheter Irrigation - Open Method

	Satis. +	Unsat. -
1. Verify doctor's order.		
2. Wash your hands.		
3. Assemble equipment: a) sterile irrigation set b) sterile irrigating solution.		
4. Identify patient.		
5. Explain the procedure.		
6. Screen for privacy.		
7. Raise bed to working height.		
8. Lower side rail on NEAR side.		
9. Assist patient to dorsal recumbent position.		
10. Open irrigation set on tray table.		
11. Remove irrigating container and stand upright without contaminating inside of drainage receptacle.		
12. Remove cap from irrigating solution and set down with rim up or hold in hand.		
13. Hold bulb syringe and cover in one hand and pour approximately 150 cc irrigating solution into container.		
14. Replace cap on solution bottle and bulb syringe into container.		
15. Pick up drape by corners and place under catheter and tubing.		
16. Then place sterile cap and alcohol wipe on drape by tipping receptacle.		
17. Cleanse junction of catheter and drainage tubing with alcohol wipe.		
18. Separate catheter from tubing and hang end of catheter over edge of drainage receptacle.		
19. Allow urine in tubing to empty into drainage bag and place sterile cap over the end.		
20. Coil tubing on bed and lay aside.		
21. Draw up 30 cc solution into syringe.		

	Satis. +	Unsat. -
22. Inject gently into the catheter, maintaining sterility.	_____	_____
23. Remove syringe; allow fluid to drain into drainage receptacle.	_____	_____
24. Repeat three or four times or until drainage returns clear.	_____	_____
25. Remove cap from drainage tubing.	_____	_____
26. Reconnect catheter to tubing, being careful to maintain sterility of both.	_____	_____
27. Reposition tubing for maximum drainage of urine.	_____	_____
28. Assist patient to comfortable position.	_____	_____
29. Raise side rail and lower bed.	_____	_____
30. Remove equipment and discard.	_____	_____
31. Report and record: a) amount of irrigating solution used. b) characteristics of the irrigation returns. c) how patient tolerated procedure. d) subtract amount of fluid instilled from the patient's urine output.	_____	_____

Comments:

_____ Satisfactory _____ Unsatisfactory

____ ____________________

Instructor Date

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ____________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ELIMINATION

Sterile Urine Specimen from a Retention Catheter

	Satis. +	Unsat. -
1. Verify doctor's order.	____	____
2. Wash your hands.	____	____
3. Assemble equipment: a) 10 cc sterile syringe. b) sterile 1 inch needle. c) alcohol wipe. d) sterile urine specimen container.	____	____
4. Identify patient.	____	____
5. Explain the procedure.	____	____
6. Screen for privacy.	____	____
7. Raise the bed to working height.	____	____
8. Lower side rail on NEAR side.	____	____
9. Cleanse drainage port on tubing with alcohol wipe.	____	____
10. Insert needle at 45° angle.	____	____
11. Withdraw 10cc urine into syringe.	____	____
12. If urine is not readily available, elevate drainage tubing slightly to return urine to the area OR clamp catheter for a short time.	____	____
13. Remove needle from drainage port.	____	____
14. Transfer urine to sterile specimen container.	____	____
15. Make patient comfortable; discard equipment.	____	____
16. Raise side rail and lower bed.	____	____
17. Label specimen and send to lab.	____	____
18. Add 10cc to patient's urinary output.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

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EAU CLAIRE, WISCONSIN
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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ELIMINATION
Removing a Retention Catheter

		Satis. +	Unsat. -
1.	Verify doctor's order.	____	____
2.	Wash your hands.	____	____
3.	Assemble equipment a) syringe (size matched to balloon) b) blue pad	____	____
4.	Identify patient.	____	____
5.	Explain the procedure.	____	____
6.	Screen for privacy.	____	____
7.	Raise the bed to working height.	____	____
8.	Lower side rail on NEAR side.	____	____
9.	Place blue pad beneath perineal area.	____	____
10.	Insert syringe into balloon inflation tube of catheter.	____	____
11.	Withdraw all the fluid; if unsure, repeat.*	____	____
12.	Gently withdraw catheter and place on chux pad.	____	____
13.	Dry perineal area with towel or provide perineal care.	____	____
14.	Measure urine in drainage bag and discard.	____	____
15.	Make patient comfortable.	____	____
16.	Raise side rail and lower bed.	____	____
17.	Record color, odor, amount and consistency of urine in drainage bag.	____	____

***More water may have been inserted into balloon than is indicated by balloon size.**

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ Instructor

____________________ Date

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ASSOCIATE DEGREE NURSING

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PERFORMANCE TEST

UNIT: ELIMINATION
Collecting a Urine Specimen by Clean Catch

	Satis. +	Unsatis. -
Female:		
1. Wash your hands.	______	______
2. Assemble equipment: a) sterile midstream urine collector kit OR b) 3 packets of antiseptic solution towelettes c) sterile urine specimen container and gloves	______	______
3. Identify patient.	______	______
4. Explain the procedure.	______	______
5. Screen for privacy.	______	______
6. Raise bed to working height and lower side rail.	______	______
7. Put on exam gloves.	______	______
8. Wash patient's external genitalia with soap and water.	______	______
9. Position patient on bedpan with legs spread apart.	______	______
10. Separate labia.	______	______
11. With first towelette, cleanse right labium, top to bottom.	______	______
12. With second towelette, cleanse left labium, top to bottom.	______	______
13. With third towelette, cleanse down center, directly over meatus, top to bottom.	______	______
14. Remove cover from specimen container.	______	______
15. Ask patient to begin urinating in bedpan.	______	______
16. After patient has begun voiding, collect specimen (30-60 cc) in sterile container.	______	______
17. After collecting specimen, allow patient to finish voiding in bedpan.	______	______
18. Dry patient's perineal area and remove bedpan.	______	______
19. Remove gloves.	______	______
20. Replace cover on specimen container.	______	______

	Satis. +	Unsatis. -
21. Label urine specimen: a) patient's name, room number b) date and time obtained c) specimen obtained by (student's name).		
22. Place label on side of container (never on cover).		
23. Send specimen to lab immediately.		
24. Chart where appropriate.		

Male

Procedure same, except:

	Satis. +	Unsatis. -
25. Grasp penis just below glans.		
26. Retract foreskin if patient is uncircumcised.		
27. Cleanse glans, beginning at meatus and moving outward in a circular motion.		
28. Repeat once or twice more, as necessary.		
29. When collecting specimen, avoid touching patient's skin with sterile container.		

Comments:

_____ Pass _____ Fail

______________________________ ______________
Instructor's signature Date

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CHIPPEWA VALLEY TECHNICAL COLLEGE
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ASSOCIATE DEGREE NURSING

Name ____________________
Nursing Skills II Packet
SELF-CHECKOFF

UNIT: OSTOMY CARE

Application of Urostomy Appliance

		Satis. +	Unsat. -
1.	Wash your hands		
2.	Assemble equipment. a) ostomy bag with flange b) stomahesive with flange (a. and b. must be same size) c) scissors d) skin prep (optional) e) paper tape = 1" size f) belt (optional) g) several gauze squares h) blue linen protector i) wash cloth, towel, soap j) gloves		
3.	Identify patient.		
4.	Explain the procedure.		
5.	Using pattern trace the stoma size on the white backing of the stomahesive and cut out. Remove the white backing from the stomahesive and set the stomahesive aside.		
6.	Don gloves.		
7.	Remove the old appliance and discard.		
8.	Place linen protector across patient's lower abdomen under stoma.		
9.	Place gauze wick or tampon on stoma.		
10.	Wash stoma and skin area with warm water. You may use a gentle soap without oils or deodorants. Pat dry.		
11.	Check skin for any redness or open areas.		
12.	Apply skin prep in a 4" area around the stoma and allow to dry. (Takes about 1-2 minutes.)		
13.	Center the stomahesive over the stoma and apply with gentle pressure and hold in place for 1-2 minutes.		
14.	Snap the ostomy bag onto the flange.		
15.	Apply strips of 1" tape in a picture frame manner around the stomahesive.		

	Satis. +	Unsat. -
16. Apply skin prep to the top of the paper tape. Use the same wipe as before. (Use of a belt is optional.)	____	____

NOTE: The best time to change a urostomy appliance is early morning, before the patient has eaten or taken any liquids, as there will be less flow of urine from the stoma.

To Connect Night Drainage System:

	Satis. +	Unsat. -
17. Hang drainage bag on side of bed (attached to frame).	____	____
18. Coil drainage tubing on top of bed.	____	____
19. Cleanse drainage port with antiseptic wipe.	____	____
20. Drain urine from collection bag; measure and record.	____	____
21. Attach drainage tubing to collection bag.	____	____
22. Check for patency of system.	____	____

NOTE: Connect to drainage system at bedtime or if patient will be napping for more than an hour.

Observe and report immediately the following:
- a) elevated temperature
- b) chills
- c) pain
- d) cloudy, foul smelling urine
- e) bloody urine
- f) decreased urine output

Comments:

____ Satisfactory ____ Unsatisfactory

______________________________ ______________________
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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name____________________
Nursing Skills II Packet
PERFORMANCE TEST

UNIT: ELIMINATION
Colostomy Irrigation

	Satis. +	Unsat. -
1. Verify doctor's order.	____	____
2. Wash your hands.	____	____
3. Assemble equipment in bathroom. a) irrigation bag with cone tip b) irrigation sleeve c) belt d) lubricant e) toilet paper f) plastic bag g) IV stand h) clean colostomy bag i) bath thermometer j) towel and wash cloth k) gloves	____	____
4. Identify the patient.	____	____
5. Explain the procedure.	____	____
6. Assess physical condition of patient.	____	____
7. If patient can tolerate sitting up for an hour, settle him/her comfortably in wheelchair in bathroom, facing toilet.	____	____
8. Lock wheels.	____	____
9. Close clamp on irrigation bag.	____	____
10. Fill irrigation bag with about 500-1000 ml of lukewarm water (100^{o}).	____	____
11. Open clamp and allow the water to run through the tube until all of the air has been expelled; close clamp.	____	____
12. Hang the bag on IV stand or hook near the toilet so that the bottom of the bag is 12-18 inches above the stoma.	____	____
13. Don gloves.	____	____
14. Remove the stoma bag, place in plastic bag.	____	____
15. Clean stoma and surrounding skin with toilet paper.	____	____
16. Apply irrigation sleeve over stoma. Use belt to keep it in place. Fold bottom of bag up to form cuff and place into toilet (or commode).	____	____

	Satis. +	Unsat. -
17. Generously lubricate the cone tip.		
18. Using a rotating motion, insert the cone tip into the stoma. Never force the cone.		
19. Open the clamp on the tubing and allow the water to flow. (If patient complains of cramping, lower container, clamp tubing, and instruct patient to take deep breaths through mouth.)		
20. Hold the cone in place after the water has flowed in for about 1-2 minutes.		
21. Remove the cone and close the top of the irrigation drain sleeve.		
22. Allow water and stool to be expelled through drain.		
23. Rinse irrigation sleeve with water and then remove.		
24. Clean the area around the stoma with soap and water and dry skin thoroughly.		
25. Remove gloves.		
26. Place 4 x 4 inch gauze square OR apply clean colostomy bag.		
27. Settle patient comfortably in bed or armchair.		
28. Wash irrigation sleeve in warm, soapy water.		
29. Chart all pertinent information about the irrigation returns.		

Comments:

_____ Satisfactory _____ Unsatisfactory

Instructor ______________________ Date ______________________

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Nursing Skills II Packet

ASSIGNMENT SHEET

UNIT: INFANT CARE

OBJECTIVE	LEARNING ACTIVITIES	LAB/GROUP	EVALUATION
Student will demonstrate competency in care of healthy infants:			
a) holding infant	View MED 334 "Baby Basics" Chapts. 4 & 5	Instructor Demo "Care of Healthy Infants"	Peer Checkoff
	Read Ladewig, London & Olds Essentials of Maternal-Newborn Nursing, 2nd Ed. pg. 624		
b) bathing infant	Read Ladewig pgs. 626, 627, 629		Pass Performance Test
c) cord care and diaper change	Read Ladewig, pgs. 627, 629; read Whaley & Wong, Essentials of Pediatric Nursing, 3rd Ed, pg. 199		Peer Checkoff
	Neeson and May, Comprehensive Maternity Nursing, pgs 1045, 1067		
d) burping and positioning	Read Ladewig, pg. 624		Peer Checkoff
e) temperature and apical pulse	Read Whaley pg. 137		Pass Performance Test
f) weight and height (length)			Clinical
g) I.M. injection--newborn	Read Ladewig, pgs. 618-619		Clinical
h) installation of eye meds	Read Ladewig, pgs. 620-621		Clinical
i) heel stick	Read Neeson, pg. 1050		Clinical
	View MED 312 (up to discussion of tubes)		
j) nasal or oral suctioning (bulb syringe)	Ladewig, pgs. 624-625		Clinical

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Nursing Skills II Packet
PEER CHECKOFF

UNIT: INFANT CARE

Holding Baby

Satis. + Unsatis. -

Demonstrate three ways baby may be held and identify appropriate times when each may be used.

Football

1. Wash hands. ______ ______
2. Pick up baby; then position baby such that holder's palm of hand is placed under baby's head and neck to support them. ______ ______
3. Baby's body rests on holder's forearm and baby is held securely against holder's body. ______ ______
4. Appropriate uses: ______ ______
   a) bathing head
   b) comforting
   c) carrying
   d) breast feeding

Cradle

1. Wash hands. ______ ______
2. Pick up baby and have baby resting in holder's bent arm, next to holder's body. Baby is in supine position. ______ ______
3. Holder uses their hand to hold baby's thigh for safety. ______ ______
4. Appropriate uses: ______ ______
   a) comforting
   b) carrying
   c) feeding (bottle or breast)

Upright Shoulder

1. Wash hands. ______ ______
2. Pick up baby with palm of hand supporting baby's head and neck. ______ ______
3. Holder's second hand holds the infant's buttocks. ______ ______
4. Baby is positioned facing holder's upper chest with baby's head on or near holder's shoulder. ______ ______
5. Holder may then keep their second hand on baby's buttocks or move it to a position below baby's buttocks between the legs. ______ ______

	Satis. +	Unsatis. -
6. Appropriate uses: a) burping b) comforting c) carrying	_____	_____

Comments:

____ Satisfactory ____ Unsatisfactory

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: INFANT CARE
Bathing Infant

	Satis. +	Unsatis. -
1. Gather equipment: a) cotton balls b) 2-3 wash cloths c) towel d) T-shirt e) diaper f) 2 receiving blankets g) mild soap (if used) h) clean sheet for crib i) wash basin with water warm to touch (elbow or wrist)	____	____
2. Wash hands.	____	____
3. Identify baby.	____	____
4. Position baby in draft-free spot.	____	____
5. Place baby on padded surface (may remain in crib) in a supine position.	____	____
6. With moistened cotton balls, which are used for only one wipe, clean:		
a) eyes from inner aspect outward.	____	____
b) face, checking nares for crusted secretions.	____	____
c) ears, inside and out.	____	____
7. Pick up and hold baby using the football hold and tilting the head slightly downward.	____	____
8. Holding baby's head over basin, moisten hair, lather rubbing gently, and then rinse pouring water from cupped hand.	____	____
9. Pat hair dry.	____	____
10. Lay baby down on padded surface and partially undress, removing T-shirt. Leave diaper on and legs covered.	____	____
11. Using and turning wash cloth so that a clean part touches skin with each stroke, continue with bath.	____	____
12. Wash neck and rinse (paying special attention to folds and creases), then pat dry.	____	____
13. Wash, then rinse chest and arms, paying special attention to axillae and creases at joints, pat dry.	____	____
14. Wash and rinse hands of baby, then dry.	____	____
15. Position on abdomen, wash and rinse back, then pat dry.	____	____

	Satis. +	Unsatis. -
16. Reposition so baby is supine, cover upper body (chest, arms), uncover infant's legs.	_____	_____
17. Wash and rinse legs and feet, then pat dry.	_____	_____
18. Remove diaper. If stool present, then wipe stool off (front to back) and discard wash cloth.	_____	_____
19. With clean wash cloth wash and rinse genitalia:		
a) vulva, front to back direction.	_____	_____
b) penis and scrotum; do not retract foreskin.	_____	_____
20. Wash and rinse buttocks and upper leg covered by diaper, then pat dry.	_____	_____
21. Dress baby putting on diaper, T-shirt and wrap in two receiving blankets.	_____	_____
22. Change crib sheet.	_____	_____
23. Clean up and wash hands.	_____	_____
24. Document how infant tolerated bath, condition of skin.	_____	_____

Comments:

_____ Satisfactory _____ Unsatisfactory

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Nursing Skills II Packet
PEER CHECKOFF

UNIT: INFANT CARE

Cord Care and Diaper Change

	Satis. +	Unsatis. -
Cord Care		
1. Obtain supplies: a) 70% alcohol preps OR b) cotton balls with 70% alcohol		
2. Wash hands.		
3. Position baby supine.		
4. Unwrap baby and expose umbilicus (usually do before diaper change and with bath).		
5. Clean base of cord with alcohol prep or alcohol moistened cotton ball.		
6. Moisten cord with alcohol and allow to dry.		
7. Change diaper as appropriate.		
8. Wrap baby in blankets and reposition.		
9. Wash hands.		
10. Document: a) cord care b) condition of cord c) diaper change		
Diaper Change		
1. Wash hands.		
2. Obtain supplies: a) 1-2 wash cloths moistened with warm water (wipes) b) diaper c) ointment for diaper rash, if present		
3. Position baby supine.		
4. Unwrap blankets.		
5. Do cord care as appropriate.		
6. Open diaper. If loose stool is present in diaper, wipe front to back with part of diaper not soiled with stool, and fold diaper over on itself to cover up soiled area of diaper.		
7. Using warm moist wash cloth, wash genital area front to back (female), penis to scrotum (male), then buttocks. Fold wash cloth so as not to use an area for more than one wipe.		

		Satis. +	Unsatis. -
8.	Remove soiled diaper and place clean diaper under baby's buttocks.	____	____
9.	Fold diaper down in front so that diaper does not touch umbilical cord.	____	____
10.	For male, position penis downward.	____	____
11.	Close diaper and tape. If cloth diaper, position two of your fingers under overlapping diaper, between diaper and infant's skin before inserting pin, front to back, over area of fingers. Close pin.	____	____
12.	Wrap baby in blanket and reposition appropriately.	____	____
13.	Dispose of diaper and wash cloth.	____	____
14.	Wash hands.	____	____
15.	Document:	____	____
	a) voiding		
	b) stool size, color, consistency		
	c) cord care, etc. (if done)	____	____

Comments:

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Nursing Skills II Packet
PEER CHECKOFF

UNIT: INFANT CARE

Burping and Positioning Baby

Satis. + **Unsatis. -**

Burping: Upright Shoulder

1. Place baby in upright shoulder position and use hand that would be used to support head and neck to rub baby's back or gently pat baby's back. ____ ____

Burping: Sitting Position

1. Baby positioned in a sitting position on holder's lap. ____ ____
2. Holder places one hand under baby's chin, with palm of hand on upper chest (to support baby's body), and the thumb and forefinger holding baby's jaw (to support baby's head). ____ ____
3. Holder uses other hand to rub or gently pat baby's back. ____ ____

Demonstrate 3 positions to place baby and verbalize when to use each.

Positioning Baby: (when to use)

1. Abdomen/prone ____ ____
   Use: after feeding, any time
2. Right side with role behind back ____ ____
   Use: after feeding, any time
   after circumcision, before cord falls off
3. Left side with role behind back ____ ____
   Use: only one and a half to two hours after feeding

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Nursing Skills II Packet
PERFORMANCE TEST

UNIT: INFANT CARE

Taking Temperature and Apical Pulse

	Satis. +	Unsatis. -
Temperature (rectal)		
1. Gather supplies: a) thermometer b) thermometer cover c) water soluable lubricant, if necessary	____	____
2. Wash hands.	____	____
3. Identify infant.	____	____
4. Position infant supine.	____	____
5. Unwrap and open diaper.	____	____
6. Take thermometer, put on cover and lubricate, if appropriate.	____	____
7. Hold infant's legs and stabilize lower torso, while exposing anus.	____	____
8. Insert thermometer 0.25 to 0.5 in. (0.5 to 1 cm) into rectum. Wait 4 minutes or until electronic thermometer beeps.	____	____
9. Rediaper, rewrap, reposition infant.	____	____
10. Clean up, put away thermometer, document.	____	____
Temperature (axillary)		
11. Gather supplies: a) thermometer with cover	____	____
12. Wash hands.	____	____
13. Identify baby.	____	____
14. Unwrap infant only as necessary to allow insertion of thermometer tip in axillary fold.	____	____
15. Take thermometer, with cover on, and place tip in axillary fold; then hold infant's upper arm snug to body.	____	____
16. Wait 5 minutes or until electronic thermometer beeps.	____	____
17. Redress, rebundle, reposition infant.	____	____
18. Clean up, put thermometer away.	____	____
19. Document.	____	____

Apical Pulse

	Satis. +	Unsatis. -
20. Gather supplies: a) stethescope b) alcohol prep		
21. Wash hands.		
22. Wipe bell of stethescope, then lower tubing well with alcohol prep.		
23. Identify infant.		
24. Position infant supine, unwrap blankets, open T-shirt.		
25. Warm bell of stethescope in hands.		
26. Place bell at 3rd to 4th intercostal space, lateral to midclavicular line or to right of lower third of sternum.		
27. Count for one minute, evaluate rhythm.		
28. Redress, rewrap, reposition infant.		
29. Document rate, rhythm.		

Comments:

_____ Satisfactory _____ Unsatisfactory

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Nursing Skills II Packet
CLINICAL

UNIT: INFANT CARE

Weight and Height (Length)

	Satis. +	Unsatis. -
Weight		
1. Wash hands.	____	____
2. Place barrier on scale (cloth or paper).	____	____
3. Zero scale.	____	____
4. Identify infant.	____	____
5. Undress infant completely.	____	____
6. Place infant on scale, always keeping one hand on or above baby.	____	____
7. Check weight at least twice or until two identical weights are obtained.	____	____
8. Redress infant.	____	____
9. Document weight.	____	____
10. Clean up scale.	____	____
Length/Height		
1. Wash hands.	____	____
2. Obtain height board or tape measure.	____	____
3. Identify baby.	____	____
4. Unwrap baby (leave dressed) and place supine in crib or on height board.	____	____
5. Place baby's head touching top of crib or height board, straighten baby's legs and measure top of bed to base of baby's heels. Check length at least twice or until get two identical lengths.	____	____
6. Rewrap baby in blankets and position properly.	____	____
7. Document.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

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CLINICAL

UNIT: INFANT CARE

IM Injections - Newborn

	Satis. +	Unsatis. -
1. Gather supplies: a) medication (vitamin K, Aqua Mephyton) b) (if in vial, need filter needle) c) syringe d) 25 g needle e) alcohol prep f) band-aid	______	______
2. Wash hands.	______	______
3. Identify patient.	______	______
4. Draw up medication following proper technique.	______	______
5. Identify vastus lateralis muscle (lateral upper thigh).	______	______
6. Wipe middle third of vastus lateralis muscle area with alcohol prep.	______	______
7. Position middle third of vastus lateralis muscle between your thumb and forefinger and press gently to bunch up muscle.	______	______
8. Quickly insert needle at 90° angle into thigh.	______	______
9. Aspirate, then slowly inject medication.	______	______
10. Remove needle and massage area with alcohol wipe.	______	______
11. Dispose of supplies.	______	______
12. Wash hands.	______	______
13. Document medication and site of injection.	______	______

Comments:

_____ Satisfactory _____ Unsatisfactory

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UNIT: INFANT CARE

Instillation of Eye Medication

Demonstrate with verbalization.

	Satis. +	Unsatis. -
1. Gather supplies: a) medication b) gloves	____	____
2. Wash hands.	____	____
3. Identify infant.	____	____
4. Open medication package.	____	____
5. Position thumb and forefinger so one is above and below eye lid.	____	____
6. Open eye lid and hold open.	____	____
7. Instill ophthalmic ointment as a narrow strand 1/2 inch (1 mm) along lower conjunctional surface of eye, starting at inner canthus.	____	____
8. Repeat steps 5-7 on other eye.	____	____
9. Dispose of supplies.	____	____
10. Wash hands.	____	____
11. Document: medication administration.	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

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Nursing Skills II Packet
CLINICAL

UNIT: INFANT CARE
Heel Stick

	Satis. +	Unsatis. -
1. Gather supplies:		
a) lancet (pediatric size)		
b) alcohol preps (1)		
c) 2 X 2		
d) capillary tubes or appropriate blood collection micro tubes		
e) band-aid		
f) warm wash cloth or chemical heat pack and tape		
2. Wash hands.		
3. Identify infant.		
4. Apply heat pack on heel; wait 3-5 minutes.		
5. Stabilize the infant's foot by placing your thumb (or forefinger) behind the heel and dorsiflexing the foot against the shin using your forefinger (or thumb).		
6. Circle in heel stick site firmly with hand but do not squeeze.		
7. Identify the stick site:		
a) lateral aspect of heel (best)		
b) medial aspect of heel (acceptable)		
8. Cleanse selected site with alcohol, wipe dry with 2 X 2.		
9. Using lancet, puncture skin with one quick, downward movement, 90° angle.		
10. Allow small drop of blood to form then wipe away with 2 X 2.		
11. Collect blood sample, avoid squeezing.		
12. Apply pressure with 2 X 2.		
13. Apply band-aid.		
14. Document:		
a) reason for blood collection		
b) amount drawn		
c) how infant tolerated procedure		

Comments:

____ Satisfactory ____ Unsatisfactory

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CLINICAL

UNIT: INFANT CARE

Nasal or Oral Suctioning (Bulb Syringe)

		Satis. +	Unsatis. -
1.	Wash hands.	____	____
2.	Get tissue and bulb syringe (should be in crib).	____	____
3.	Position infant in supine position.	____	____
4.	Stabilize head and hold secure.	____	____
5.	Compress bulb syringe.	____	____
6.	Insert tip of syringe in nostril.	____	____
7.	Allow bulb of syringe to re-expand slowly.	____	____
8.	Remove syringe from nostril.	____	____
9.	Recompress syringe to remove drainage into a tissue.	____	____
10.	Repeat 5-9 until both nostrils clear.	____	____
11.	Compress bulb syringe.	____	____
12.	Insert bulb syringe one inch into one side of infant's mouth.	____	____
13.	Allow bulb syringe to re-expand.	____	____
14.	Remove syringe from mouth.	____	____
15.	Recompress syringe to remove drainage into a tissue.	____	____
16.	Repeat 11-15 on each side of mouth until clear.	____	____
17.	Evaluate passageways for patency, evaluate respirations.	____	____
18.	Wash bulb syringe in warm soapy water, rinse and dry.	____	____
19.	Wash hands.	____	____
20.	Document: a) how infant tolerated procedure b) amount, color, consistency of drainage	____	____

Comments:

____ Satisfactory ____ Unsatisfactory

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EXHIBIT H

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing-Technical Program

Course Syllabus

COURSE: 510-110 Introduction to Nursing

CREDITS: Section I Theory - 1 credit (Weeks 1-9)
Challenge options available for NA, LPN.
Section II Theory - 1 credit (Weeks 10-18)
Challenge options available for LPN.
Section III Clinical - 1 credit (Weeks 10-17)
Challenge options available for NA, LPN.

PREREQUISITES: 510-101 Nursing Skills I

LEAD INSTRUCTOR: Eleanor Walter

RESOURCES:

Textbooks: Kozier, Erb, and Bufalino, Introduction to Nursing, 1st Edition, Addison-Wesley, 1989.

References: Kozier, Barbara and Erb, Genna, Techniques in Clinical Nursing, 3rd Edition, Addison-Wesley, 1989.

Lecture and Reading List Prepared by Faculty.

COURSE DESCRIPTION:

The goal of this course is to build on knowledge and skills acquired in prior learning experiences in order to provide a basis for understanding basic nursing practice. Psychosocial, behavioral, biological, cultural, and spiritual concepts provide the theoretical background that serves to sensitize the student to the unique needs of each patient and the role of the nurse as a provider of care. Scientific principles and ethical, legal guidelines for behaviors give direction for maintaining a safe, supportive patient care environment.

COURSE OBJECTIVES:

Upon successful completion of this course, the student will be able to:

Knowledge Base

Ia. Identify behaviors that promote successful learning.

Ib. Identify behaviors that promote positive relationships.

Ic. Identify responsible and ethical behavior of members of the nursing team.

Id. Identify effective verbal and non-verbal communications skills.

Ie. Identify behaviors that are supportive to patients and their families.

Performance Competencies

If. Provide a safe patient care environment.

Ig. Use nursing care measures that meet the unique needs of individual patients.

Ih. Protect the rights of the patient.

Ii. Protect the health of self, the patient and co-workers while providing patient care.

Ij. Apply the principles of written communication when reporting and recording information.

Ik. Use appropriate terminology when reporting and recording information.

Critical Thinking

Il. Apply knowledge and skills from past and current educational experiences to new situations.

Im. Move progressively from application of concepts to one's own experiences, to more abstract applications of concepts to the experiences of others.

Humane Caring

In. Demonstrate culture/ethnic/age sensitive communication and behavior skills that are supportive to patients and their families.

Io. Apply the concept of caring as the primary purpose of nursing, and the concept of neglecting as an impediment to that purpose.

INSTRUCTION:

Section I - Eight Units

Section II - Nine Units

Section III - Clinical Practice (8 weeks: Long Term Care, Support Services)

Method of Instruction

Large group lectures
Small group discussions
Autotutorial materials
Supervised clinical laboratories
Pre and post clinical conferences
Individual student conferences
Self-directed study

Methods of Evaluation

Written examinations
Evaluation of clinical competency
Assessment of prior learning through challenge examinations

POLICIES AND PROCEDURES

Grading

Course grade is derived as follows:

Section I - 3 unit exams
Section II - 3 unit exams
Section III - Evaluation of clinical competency (see attached form).

Independently, the student is expected to complete the required reading and assignments.

The theory comprises 70% of the course grade and is derived from unit examinations. Clinical laboratory experiences comprise 30% of the course grade. The student must achieve a passing grade in each unit in order to pass the course. The lowest acceptable passing grade is a C- (75%).

If a student fails an examination, s/he is expected to make an appointment with the lead instructor. If a student is absent on the day of an examination, s/he must contact the lead instructor within two school days regarding a makeup or receive a score of "0" for the examination. Cheating results in a "0" on that examination with no option for make-up.

Students clinical performance is evaluated by clinical instructors using the point system reflected on the evaluation form. The student is expected to see his/her clinical instructor (by appointment) every three weeks to monitor their progress.

Class

Clinical attendance is extremely important. Excessive clinical absence will make it difficult or impossible to achieve the clinical competencies. If excessive absences occur, the clinical instructor will not be able to validate safe clinical practice. Limited opportunities exist for make-up days.

Attendance

Roll will be taken at the beginning of each class. Absences are recorded and reported to Student Services where they are recorded on the student's record. Students with excessive absences are referred to a Student Services counselor. Students are expected to formulate a plan to correct the behavior.

Reporting Absence

CLASS:

Call (715) 833-6417.

Identify yourself, the information regarding absence and the name of the instructor in each class for which you will be absent.

CLINICAL LABORATORY:

Call the nursing unit.

Identify yourself, your instructor and the message regarding your absence.

Challenge Options

Licensed Practical Nurses may elect to challenge Course Sections I-II-III. Nursing Assistants may elect to challenge Section I and Section III. Students choosing challenge options are expected to follow the guidelines identified in the "Guidelines for Nursing Challenge Examination Document". This document is available through the nursing division secretary.

SECTION I
Course Overview

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
0.1 Define the key terms in the syllabus and course outline.	Key terms	Review course syllabus and outline.
0.2 Identify some helpful guidelines students might use to relate the concepts from prior learning to new learning.	How prior learning is integrated: non-nursing courses nursing skills medical terminology	Review the learning process.
0.3 Develop the ability to use nursing program resources.	Resources Instructor Texts Reference How to use resources	Review the components of the textbook.
0.4 Recognize organization, issues and conclusions of text authors.		Participate in exercises that promote the ability to recognize organization, issues and conclusions of expository texts.

UNIT I: Introduction to Concepts

The concepts introduced in this course will be expanded upon in future courses. Lecture and discussion will be enhanced by the learning activities listed in the right column.

1.1 Describe with examples five facets of the unique person.	The Unique Person facets: Cultural Social Ethnic Spiritual Generational	Discuss own characteristics of and share with the group.
1.2 Give two examples of positive nurse-patient relationships.		Role play examples of positive relationships.
1.3 Describe an example of nonacceptance of a person's individuality and the effect on the nurse-patient relationship.	Support System: family, friends, society. Acceptance Choices	Discuss case study using examples of acceptance and non-acceptance of person's individuality.
1.4 Define gender-role behavior.	Sexuality behaviors acceptance	
1.5 Describe an example of supportive recognition of gender-role behavior.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
UNIT II: The Health Care System		
2.1 Define the key terms: health, illness, health care, health care agency, health care team, job description.	Health Care Services non-acute acute	Discussion of personal definitions of health, illness.
2.2 Identify two examples of nonacute health care services.	Agency purpose	
2.3 Identify the roles of nursing assistant, licensed practical nurse and registered nurse as members of the health care team.	Health Team roles responsibilities job description	
2.4 Give three examples of non-nursing members of the health care team in a long term care setting.		
UNIT III: The Role of the Nurse		
3.1 Apply the principles of communication skills to examples of nurse-patient interactions.	Communication non-verbal behavior active listening common barriers intradiscipline confering	Videotape Critique body language and barriers.
3.2 Identify five common barriers to communication.	Responses assertive aggressive passive	
3.3 Identify two techniques that are helpful when communicating with people who have impaired communication.		
3.4 Describe the differences between assertive, passive, and aggressive responses.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
3.5 Apply terms and abbreviations from medical terminology to oral and written communication.	Records purpose of records types of records	Group practice reporting recording
3.6 Describe an example of violating confidentiality of a patient's record.	Guidelines confidentiality compliance channels complaints	Role play violation of confidentiality.
3.7 Identify three deviations of normal body function that could be life threatening.	Observation skin color respiration alertness deviations	Simulation of response to codes.
3.8 Describe an example of verbal report that includes all of the components of a report.	Reporting, Recording components of a report recording information task list patient responses abuse situations	Simulation of assignments, reporting to instructor.
3.9 Identify the process of recording and reporting information related to patient care.		
3.10 Identify the steps in reporting patient abuse.		Discussion of incident of patient abuse and steps in reporting.

UNIT IV: Hazards

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
4.1 Identify the steps taken to protect self and others in the event of a fire.		
4.2 Identify three characteristics of a safe environment.	Physical: fire prevention choking falls electrical restraints immobility lifting and moving violent patient behavior	
4.3 Identify four precautions to prevent falls, accidents and injuries.		Film on accident prevention in hospital.
4.4 Describe two situations in which restraints are warranted.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
4.5 Identify the guidelines for selecting and applying restraints.		
4.6 Identify three safety measures useful in managing violent behavior.		
4.7 Give two examples for patients at risk for physical injury.	Principles of abuse verbal abuse nonverbal abuse	Role play subtle examples of abuse.
4.8 Describe four environmental sanitation measures.	Biological asepsis microorganisms	Handouts
4.9 Describe two precautions when handling disinfectants and pollutants.	Chemical disinfectant pollutants	
	UNIT V: Personal Care	
5.1 Apply concepts from science courses to maintaining the integrity of the skin.	Skin care observations white, non-white generational changes deviations due to pressure cleansing	Reading assignments
5.2 Describe with examples racial variations in the appearance of the skin, nails, and mucous membranes.	Oral care observations Grooming observations	
5.3 Identify two common problems nurses encounter in maintaining skin integrity in their patients.	Dressing observations	
5.4 Describe three factors that make a person susceptible to skin breakdown.		
5.5 Identify with examples skin changes that are indicative of skin breakdown.		Discussion Self-help motivation

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
5.6 Identify the elements of grooming with examples of the nurse's role in grooming, comfort and dressing.		
5.7 Describe two environmental factors that promote comfort.	Maintaining environment comfort warmth order	
5.8 Identify supportive and assistive devices commonly used in long term care.	Managing Adaptive Devices Supportive devices Assistive devices	Discussion Devices
5.9 Describe two examples of how adaptive devices are useful in maintaining independence.		
5.10 Identify the major concepts and principles basic to body mechanics as outlined by Kozier et al.	Mobility motivation self care moving and walking promoting independence	
5.11 List four purposes of exercise.		
5.12 Identify five kinds of exercise with examples of the positive effects of exercise.		
5.13 Describe three examples of nursing measures that help prevent immobility, and maintain joint mobility, muscle strength and endurance.	Immobility patients at risk physiologic responses psychosocial responses recognizing limitations breathing exercises	
5.14 Describe the importance of breathing exercise for people who have limited mobility.		Discussion Examples of problems due to limited mobility

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	UNIT VI: Food and Fluids	
6.1 List the four food groups with examples of foods in each group.	Essential foods modifications special needs	Handout
6.2 Describe two examples of ethnic, cultural, religious variations in food habits.	Fluid needs daily intake measurements	Discussion: ethnic/ cultural variations in diet
6.3 Describe how a nurse assures that diet modifications and special food needs are met for individual patients after the food is delivered to the nursing unit.		
6.4 Describe three helpful methods for encouraging patients to eat and drink adequate amounts of food and fluids.		
6.5 Identify the normal daily intake and output of adults.	Elimination bowel bladder observations normal deviations	
6.6 Identify the normal color of urine and feces.		Simulation of descriptive report of elimination pattern.
6.7 Give three examples of deviations in normal elimination in terms of color, consistency and amount.		
6.8 Identify two factors that influence fecal elimination.		Collect examples of common fallacies related to elimination.
	UNIT VII: Relationships	
7.1 Describe two examples of empathy; one in a nursing and one in a nonnursing situation.	Behavior Supportive Nonsupportive	

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
7.2 Give an example of nonsupportive behavior of the nurse in nurse-patient situation.	Caring descriptor of caring	
7.3 Give an example of actual and perceived inappropriate touching in a nurse-patient relationship.	Touching appropriate inappropriate combative	Brainstorming appropriate inappropriate
7.4 Give an example of a patient's combative behavior and the appropriate response of the nurse in dealing with the behavior.		Video Handout
7.5 Describe an example of caring and support to the patient and family dealing with loss.	Grieving and Loss home freedom health family life	

UNIT VIII: Legal-Ethical Issues

8.1 Give an example of negligent care.	Rights patients nurse	Discussion of examples of negligence and interpretation of false imprisonment.
8.2 Give an example of false imprisonment.		
8.3 Identify the rights of patients, nurses and students within the framework of a health care agency.		
8.4 Describe an example of how personal values can conflict with nursing responsibilities.		

SECTION II

Some concepts addressed in this unit build on the concepts introduced in Unit I. Several new concepts are introduced.

UNIT I: Communication As a Process

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
9.1 Given six examples of communication processes, differentiate between personal and object communication.	Interpersonal personal communication object communication	Role play humanizing, dehumanizing forms of interaction.
9.2 Describe the appropriate channel of communication flow in a nursing unit.	Channels of Communication Benefits of effective communication Perils of ineffective communication strategies stereotypes	Simulation exercise Discussion of roles.
9.3 Identify two strategies that promote effective communication when you need to communicate with a "busy" person.		
9.4 Identify two sources of data.	Data Collection Types, Sources Methods of data collection Interview Techniques establishing goals realistic time frame structure spatial needs parameters questions closure	
9.5 List examples of subjective and objective data.		
9.6 Define nursing assessment.		Checklist of Dos and Don'ts
9.7 Identify the purpose of data collection.		
9.8 Describe three approaches to problem solving.	Limitations recognizing your limitations recognizing client limitations when to seek help	Group project Interviews
9.9 Describe how to use interview techniques that are most likely to illicit accurate data.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
9.10 Given a simulation of client situation, develop an interview plan for data collection.		
9.11 Identify the symbols and abbreviations used in charting.	Reporting and Recording	
9.12 Describe the components of a patient's chart.	Charting symbols abbreviations progress records flow sheets guidelines standards	Handout Simulated practice charting.
9.13 Identify the measures to ensure that records meet legal standards.		
9.14 Identify the essential guidelines for reporting patient data.	Reporting guidelines discriminating data computerized records	
	UNIT II: Loss and Grief	
10.1 Identify four types of loss.	Types of loss reactions stages of grieving stages of dying	Video
10.2 Identify the characteristics and type of grief.		
10.3 Describe two factors contributing to unresolved grief and a sense of hopelessness.	Support Systems roles patients family health care team friends	Discuss views of members of support system
10.4 Describe two examples of cultural variations in dealing with grief.		
10.5 Identify the Kubler-Ross stages of dying.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
10.6 Describe an example of a common fear associated with dying and some common responses that are supportive.	Physical attending at life closure supportive comfort measures enviromental concerns	Discussion of personal experiences with dying.
10.7 Describe an example of behavior that interferes with the grieving process.		
10.8 List four physical comfort measures nurses need to incorporate in routine personal care at life's closure.		

UNIT III: Legal-Ethical Issues

11.1 Identify two kinds of legal actions.	Law and Nursing function of the law definitions	
11.2 List five ways in which nurses can protect themselves from lawsuits.	types of legal actions privileged information contracts	Video/discussion Lecture Handout
11.3 Define contract, informed consent, code, standard, liability, malpractice, assault, tort, crime, battery.	informed consent codes and standards wills Legal concepts Good Samaritan Act	
11.4 Describe an example of a violation of privileged information.	codes of ethics standards decisions options	
11.5 Describe the responsibility of the nurse in witnessing a will.		
11.6 Describe an example of a nurse assuming responsibility for his/her own practice.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
11.7 Identify two nursing practice related variables involved in the ethical decision making process.		
	UNIT IV: Elimination	
12.1 Apply concepts from anatomy and physiology to normal bladder and bowel structure and function.	Urinary normal constituents psychosocial aspects related to bladder functioning	Handout Training guides
12.2 List the normal constituents of urine.	Assessment parameters	
12.3 Identify one example of psychosocial stressors related to urinary function.	Common problems bladder training nursing strategies conferring	
12.4 Describe assessment of normal urinary elimination.		
12.5 Describe an example of nursing strategies that promote normal elimination.		
12.6 Describe two adaptive strategies that are helpful for patients experiencing urinary incontinence.		Group development of strategies.
12.7 Identify two common urinary problems the elder patient is most likely to experience.		
12.8 List the normal constituents of feces.	Fecal Normal constituents psychosocial aspects related to bowel functioning assessment parameters	
12.9 Identify three factors that influence fecal elimination.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
12.10 Identify two common social beliefs related to fecal elimination.	Factors that affect defecation strategies social beliefs	Discussion Social norm
12.11 Describe four common nursing interventions to maintain normal fecal elimination.	Common fecal elimination problems nursing strategies medical management enemas	 Handout
12.12 Identify four common medical actions to restore normal fecal elimination.	suppositories softeners laxatives Bowel training conferring	
12.13 Describe the purpose and the types of enemas.		
	UNIT V: Comfort	
13.1 Describe how to assess patients for comfort during transfer.	Assessing for comfort Guidelines for moving patients	Discussion Examples of interferences
13.2 Describe how to assess patients for comfort when at rest.		
13.3 Identify six conditions promote comfort and rest.	Conditions that promote comfort and rest physiological psychological	
13.4 List three common human biorythmic cycles.	environmental nursing interventions	
13.5 Identify the characteristics of NREM and REM sleep.	Sleep stages generational needs	
13.6 Describe an example of the effects of sleep deprivation on performance.	Interferences biological psychological	
13.7 Identify two nursing interventions that promote sleep.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
	UNIT VI: Maintence of Skin Integrity	
14.1 Identify the criteria for assessing mobility/immobility status.	Concepts related to mobility factors affecting mobility responses to immobility nursing interventions	Simulation - assessment
14.2 Describe four generational related impairments that require adaptive measures when moving patients.		
14.3 Describe four stages in the formation of pressure sores.	Interruptions in skin integrity decubitus care formation prevention	
14.4 Identify factors that contribute toward the formation of decubitus ulcers.	Restoration of skin integrity mechanical devices medical and surgical treatment	Video
14.5 Describe guidelines for nursing intervention to treat and prevent decubitus ulcers.		
	UNIT VII: Hazards	
15.1 Describe an example of an environmental hazard where the elder patient is "at risk".	Physical hypothermia hyperthermia	Case Study, Elder
15.2 Identify four precautions when using heat and cold related to nursing interventions.	Precautions heat cold	
Heat and Cold Therapy:		
15.3 Identify physiologic responses to heat and cold.	Physiologic responses to heat and cold	Discussion - "at risk" patient

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
15.4 Identify indications and purposes for heat and cold applications.	Indication for the use of heat and cold Assessment for heat and cold	
15.5 Identify contraindications and precautions for use of heat and cold.		
15.6 Identify recommended temperatures for heat and cold applications.	Method of applying dry and moist heat and cold.	
Biological:		
15.7 Apply the concepts from prior learning related to the behavior of microorganisms to the chain of infection.	Protection asepsis biologic safety chain of infection stages of an infectious process factors affecting risk of infection nosocomial infections assessment	Exercise Track process of infection
15.8 Identify six links in the chain of infection.		
15.9 Describe an example of an environmental condition favorable to the growth of microorganisms.	Nursing strategies isolation information control	
15.10 Describe three modes of transmission including methods of isolation relative to the mode.		
15.11 Identify four stages of the infectious process.		
15.12 Describe natural and acquired immunity.	Protecting body defenses client self co-workers protective devices	Simulated case isolation using CDC guidelines
15.13 Identify the signs of localized and systemic infections.		

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
15.14 Describe two deviations from normal wound healing that are indicative of an infectious process.	Signs of infection temperature skin reaction	
	UNIT VIII: Wound Care	
16.1 Identify internal and external factors that inhibit wound healing.	Types of wounds Wound healing Types of wound drainage	Video
16.2 Identify two basic ways in which wounds heals.	Factors that affect wound healing	
16.3 Describe assessment criteria of a clean, healing wound.	Sequential signs of primary wound healing	
16.4 List nursing strategies to promote wound healing and prevent complications of wound healing.	Complications of wound healing Assessment of wound healing	
16.5 Identify commonly used dressing materials, types of binders and basic terms used in bandaging.	Supporting immobilized wounds Purposes of bandages and binders Guidelines for bandaging	Discussion - Protection of self and patient
	UNIT IX: The Normal Aging Process	
17.1 Identify four functional changes related to the aging process.	Biology of Aging Physical and functional changes Results of hypomobility	Group Discussion
17.2 Describe your own view on aging.		Views on Aging
17.3 Describe an example of a physical change that is related to hypomobility.	Sociology of Aging Societal definition of aging Disengaging	Write definitions of aging

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
17.4 Describe an example of a shift in a social role due to the aging process.	Shifting outlooks and roles The American view on aging Socio-economic status	
17.5 Identify three factors that need to be assessed in order to form the basis for age sensitive care.	Ego-integrity and positive self-concept Perceptions Attitudes, beliefs, spiritual values Assessment Alterations Strengths	
Cross Cultural Perspectives on Aging;		
17.6 Identify how culture influences the way aging is defined and viewed, citing one culture as an example.	Socio-economic Status Health Care Access Responses to Growing Old Caring Practices Specific to Culture	Handout Caring Practices
17.7 Describe three features of aging that are common across cultures.	Culturally Appropriate Network Assessment language practices	Case studies
17.8 Identify two examples of culture-specific caring practices.	social network spiritual values	
17.9 Describe at least five factors that need to be assessed in order to form the basis for culturally sensitive care.		

CHIPPEWA VALLEY TECHNICAL COLLEGE
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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I
UNIT V: Personal Care

1. You are assigned to meet the personal care needs of a client. What does that involve?

2. Personal care is highly personal and individual. List four factors that influence personal care.

3. Give four reasons for bathing.

4. Give two reasons for a back rub.

5. The major emphasis of skin care is to prevent skin breakdown and infection. What conditions place clients at risk for developing skin impairment?

SR/9-89/bh
ITN/Perscare. F89

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INTRODUCTION TO NURSING
Clinical Preparation Worksheet

Initials: __________ Age: ____________ Room Number: __________

Medical Diagnosis:

Pathophysiology: (Brunner)

Signs and Symptoms (Clinical Manifestations)

Text	Patient

Nursing Diagnosis or Problems:

ITN Clinical Preparation Sheet
Page 2

Nursing Intervention:

Text	Patient

EW/10-89/bh
ITN/PrepWkst.F89

CHIPPEWA VALLEY TECHNICAL COLLEGE
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INTRODUCTION TO NURSING - SECTION I
NUTRITION CASE STUDY

Mrs. Mozelli is a 72-year-old Italian woman who was admitted to a long term care unit for rehabilitation for a fractured hip. She has lived most of her life in a small American city. Her children live far distances and visit twice a year. Mrs. Mozelli has two close friends with whom she attends church and social functions. She states she has become less active because of feeling tired. She has been diagnosed as having nutritional anemia and has significant weight loss. She states her clothes and her false teeth don't fit as well and that food doesn't taste the same. She also has problems with constipation.

24 Hour Diet Intake for Mrs. Mozelli

Breakfast: coffee and Danish

Lunch: tomato and lettuce on toasted white bread, coffee (black)

Snack: tomato juice and green tossed salad

Dinner: meat ball sandwich, coffee (black), garlic bread

Snack: coffee, doughnut

1. Identify strengths and weaknesses of Mrs. Mozelli's diet.

2. How can we modify her diet to improve her health status?

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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I

ESSENTIAL NUTRIENTS - FOOD SOURCES

To be well-nourished, we must eat foods that:

- supply heat and energy.
- build and repair body tissue.
- regulate body functions.

These foods are called nutrients. The six nutrients essential to maintain health are:

- proteins
- carbohydrates
- fats
- minerals
- vitamins
- water

Protein

Protein is an essential nutrient. It is the basic material of every body cell. It is the only nutrient that can make new cells and rebuild tissue. The foods that contain the greatest amount of protein come from animals. They include:

- meat
- poultry
- eggs
- milk
- cheese

Proteins are made of small building blocks (amino acids). The body can manufacture some of the amino acids. It cannot manufacture all of them.

> **Complete Proteins:** proteins that contain all the amino acids the body cannot manufacture. Examples of complete proteins are meat, fish, eggs, and poultry.
>
> **Incomplete Proteins:** although still important, do not contain all the essential amino acids. Essential amino acids are those that must be obtained through foods. Examples of incomplete proteins are corn, soybeans, peas, nuts and whole grain products.

Carbohydrates and Fats

Carbohydrates and fats are called energy foods because the body uses them to produce heat and energy. When a person eats more energy foods thatn the body needs, the remainder is stored as fat. Foods that contain the greatest amount of carbohydrates come from plants. They include:

- fruits
- vegetables
- foods that are made from fruits and vegetables such as breads, cereals, and pasta products

Carbohydrate foods also supply the body with roughage (cellulose). Cellulose is important in maintaining bowel regularity. Food sources for carbohydrates include:

- cereal grains and their products (bread, breakfast cereals, macaroni products)
- sugar
- fruits
- milk
- potatoes
- syrups
- vegetables
- nuts

Fats come from both plants and animals. Examples of foods that are rich in fat include:

- pork
- butter
- nuts
- whole milk
- egg yolk
- cheese
- cream

Vitamins and Minerals

Vitamins and minerals are present in a wide variety of foods. The best way to be sure that you are getting enough vitamins and minerals is to include a variety of foods in the daily diet.

Vitamins are substances that regulate body processes. They help to:

- build strong teeth and bones.
- promote growth.
- aid normal body functioning.
- strengthen resistance to disease.

You probably know the vitamins by their letter names:

- Vitamin A
- B-complex vitamins
- Vitamin C
- Vitamin D
- Vitamin E
- Vitamin K

Fat-soluable vitamins do not dissolve easily in water. They can be stored in the body. Vitamins A, D, E, and K are fat-soluble vitamins.

Vitamins B and C are water soluble. Water-soluble vitamins dissolve in water. They can be lost in the cooking process. In general, **these vitamins are not stored in large amounts. Deficiencies in water-soluble vitamins are more common.**

Minerals help to build body tissues, especially the bones and teeth. They also regulate the chemistry of body fluids such as the blood and digestive juices. Minerals needed in our daily diet include:

- calcium
- phosphorus
- iodine
- iron
- copper
- potassium

Mineral	Mineral's Bodily Function	Food Sources
Iron	Builds and renews hemoglobin, the red pigment in blood which carries oxygen from the lungs to the cells.	Eggs, meat, especially liver and kidney; deep-yellow and dark green vegetables; potatoes, dried fruits, whole-grain products; enriched flour, bread, breakfast cereals.
Iodine	Enables the thyroid gland to perform its function of controlling the rate at which foods are oxidized in the cells.	Fish (obtained from the sea), some plant-foods grown in soils containing iodine; table salt fortified with iodine (iodized).
Calcium	Builds and renews bones, teeth, and other tissues; regulates the activity of the muscles, heart, nerves; and controls the clotting of blood.	Milk and milk products, except butter; most dark green vegetables; canned salmon.
Phosphorus	Associated with calcium in some functions needed to build & renew bones & teeth. Influences the oxidation of foods in the body cells; important in nerve tissue.	Widely distributed in foods; especially cheese, oat cereals, whole-wheat products, dry beans and peas, meat, fish, poultry, nuts.

Vitamin	Vitamin's Bodily Function	Food Source
Vitamin A	Necessary for normal functioning of the eyes, prevents night blindness. Ensures a healthy condition of the skin, hair, and mucous membranes. Maintains a state of resistance to infections of the eyes, mouth and respiratory tract.	One form of Vitamin A is yellow and one form is colorless. Apricots, cantaloupe, milk, cheese, eggs, meat organs, (especially liver and kidney), fortified margarine, butter, fish-liver oils, dark green and deep yellow vegetables.
B Complex B_1 (Thiamine)	Maintains a healthy condition of the nerves. Fosters a good appetite. Helps the body cells use carbohydrates.	Whole-grain and enriched grain products; meats (especially pork, liver and kidney), dry beans and peas.
B_2 (Riboflavin)	Keeps the skin, mouth, and eyes in a healthy condition. Acts with other nutrients to form enzymes and control oxidation in cells.	Milk, cheese, eggs, meat (especially liver and kidney), whole grain and enriched grain products, dark green vegetables.

Vitamin	Vitamin's Bodily Function	Food Sources
Niacin	Influences the oxidation of carbohydrates and proteins in the body cells.	Liver, meat, fish, poultry, eggs, peanuts; dark green vegetables, whole-grain and enriched cereal products.
B_{12}	Regulates specific processes in digestion. Helps maintain normal functions of muscles, nerves, heart, blood--general body metabolism.	Liver, other organ meats, cheese, eggs, milk, leafy green vegetables.
Vitamin C	Acts as a cement between body cells, and helps them work together to carry out their special functions. Maintains sound condition of bones, teeth, and gums. Not stored in the body.	Fresh, raw citrus fruits and vegetables--oranges, grapefruit, cantaloupe, strawberries, tomatoes, raw onions, cabbage, green and sweet red peppers, dark green vegetables.
Vitamin D	Enables the growing body to use calcium and phosphorus in a normal way to build bones and teeth.	Provided by Vitamin D fortification of certain foods, such as milk and margarine. Also fish-liver oils and eggs. Sunshine is also a source of Vitamin D.

THE FOUR FOOD GROUPS

Group 1: Milk Group

This group provides calcium, phosphorus, riboflavin, protein, vitamin A, and fat. People need varying amounts of the nutrients.

MILK:
- 3 to 4 cups (children)
- 4 or more cups (teenagers)
- 2 or more cups (adults)
- 1 quart (pregnant women)
- 1 1/2 quart nursing mothers

Cheese, ice cream and other milk-made foods can be substituted for part of the milk requirement.

MILK SUBSTITUTES:
- 1 ounce cheddar-type cheese
- 4 ounces cream cheese
- 12 ounces cottage cheese
- 1 3/4 cups ice cream

Milk is available in the following forms:
- whole milk
- skim milk
- evaporated milk
- condensed milk
- buttermilk
- dried milk

Group 2: Vegetables and Fruit

4 or more servings including dark green or deep yellow vegetables: citrus fruit or tomatoes

A. Leafy, Green, and Yellow Vegetables

Use vegetables raw, cooked, frozen, or canned.
This group provides vitamin A, calcium, and iron.
Leafy green vegetables furnish riboflavin and niacin, which are both B vitamins.

One or more servings daily:
- asparagus, green
- beans, snap, green, lima
- broccoli
- brussels sprouts
- cabbage, green
- carrots
- chard
- collards
- endive, green
- escarole
- kale
- lettuce, leaf
- mustard greens
- okra
- parsley
- peas, green
- peppers, green and red
- pumpkin
- spinach
- squash, winter
- sweet potatoes
- turnip greens
- wild greens
- other greens including salad greens

B. Citrus Fruit, Tomatoes, and Raw Cabbage

This group consists of foods high in vitamin C.
This group provides vitamin A and the B-complex vitamins.
The leafy green vegetables listed provided some iron and calcium.

One or more servings daily:
- broccoli
- cabbage, raw
- limes
- oranges

cantaloupe (muskmelon)
grapefruit
grapefruit juice
greens, salad
kumquats
lemons
peppers, green, raw
pineapple, raw
strawberries, raw
tangerines
tomatoes and juice
turnips, raw

C. Potatoes and Other Vegetables and Fruits

Use foods in this group raw, cooked, frozen, canned, or dried. When eaten in fairly large amounts, foods in this group provide thiamine, vitamins A and C, calcium, and phosphorus.

Two or more servings daily

apples
apricots
artichokes
avocados
bananas
beets
berries
cabbage, white
cauliflower
celery
cherries
corn, sweet
cranberries
cucumbers
currants
dates
eggplant
figs
grapes
leeks
lettuce, head
mushrooms
onions
parsnips
peaches
pears
persimmons
pineapple, canned
pineapple juice, canned
plums
potatoes
prunes
radishes
raisins
rhubarb
rutabaga
salsify (oysterplant)
sauerkraut
squash, summer
sweet potatoes
turnips

Group 3: Meat and Fish

3 servings (children, teenagers)
2 servings (adults)
Meats, fish, poultry, eggs, or cheese, with dry beans, peas, nuts as alternates, peanut butter, soybeans, soy flour

This group provides protein, some fat, iron, phosphorus, and B-complex vitamins.

Group 4: Breads, Cereals, and Potatoes

4 or more servings
Enriched or whole grain. Added milk improves nutritional value.

This group provides carbohydrates, thiamine, niacin, iron, and roughage.

Food Sources:

BREADS: whole wheat, dark rye, enriched cornmeal, whole grain enriched or oatmeal; rolls or biscuits made with whole wheat or enriched flour
FLOUR: enriched, whole wheat, other whole grain
GRITS, ENRICHED CEREALS: whole wheat, rolled oats, brown rice, converted rice, other cereals, if whole grain or restored
NOODLES, SPAGHETTI, MACARONI

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EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I
FOODS AND MODIFICATION FOR SPECIAL NEEDS

Objectives:

After discussion of content on Foods and Modification for Special Needs you will be able to:

1. list the four basic food groups and identify numbers of servings needed for specific groups of people.
2. identify the foods included in each of the basic food groups.
3. identify essential nutrients and food sources including food sources for iron, iodine, calcium, phosphorus, vitamin A, vitamin B_1 (Thiamine), vitamin B_2 (Riboflavin, Niacin), B_{12}, vitamin C, and vitamin D.
4. explain what is meant by "therapeutic diet".
5. describe various kinds of therapeutic diets.
6. explain the purpose of each type of therapeutic diet.
7. identify foods to be allowed and those to be restricted on the various therapeutic diets.
8. list safety factors important in feeding a client.
9. know the proper technique for feeding a client.
10. identify the appropriate procedure for preparing patient for meals.
11. identify types of liquid diets and foods allowed and restricted on these diets.

Post-Operative Dietary Regime (Routine)

1. ice chips/sip of water
2. clear liquids
3. full liquids
4. soft diet
5. regular diet

Following surgery, intake is restricted until full recovery from anesthesia is made. Then the intake is changed as tolerance increases.

For patients having surgery or lab tests, watch Hollister signs for:
NPO
No breakfast
Hold breakfast
Clear liquids only
Full liquids

Liquid Diets

CLEAR LIQUID DIET: This is a temporary diet because it is an inadequate diet. It is made up primarily of water and carbohydrates for energy.

Feedings are given every two, three, or four hours as prescribed by the physician. It replaces fluids that may have been lost by vomiting or diarrhea. The clear liquid diet consists of liquids that do not irritate, cause gas formation, or encourage bowel movements (defecation).

Foods allowed on the clear liquid diet include:

1. tea, coffee with sugar but without cream
2. strained fruit or vegetable juiced with gelatin (occasionally)
3. fat-free meat broths
4. Ginger Ale (usually), 7-Up, Coke, strained grape or apple juice
5. gelatin (occasionally)

FULL LIQUID DIET: The full liquid diet does supply nourishment and may be used for longer periods of time than the clear liquid diet. Six to eight ounces are usually given every two to three hours.

The full liquid diet is give to:

1. those with acute infections.
2. patients who have difficulty chewing.
3. those who have conditions that involve the digestive tract.

The diet includes all of the foods allowed on the clear liquid diet in addition to the following:

1. strained cereal (gruel)
2. malted milk
3. strained soups
4. milk and cream
4. sherbet
5. plain ice cream
6. gelatin
7. junket
8. eggnog
9. strained vegetables and fruit juices

Therapeutic Diets

A diet that is prepared for patients with individual health problems and who have special nutritional needs; also called special diet, restricted diet, modified diet.

TYPES OF DIETS GIVEN TO PATIENTS; WHAT THEY ARE AND WHY THEY ARE USED

Type of Diet	Description	Common Purpose	Foods Often Recommended	Foods to Avoid
Normal regular	Provides all essentials of good nourishment in normal forms	For clients who do not need special diets		
Soft (mechanical)	Same foods as on a normal diet, but chopped or strained	For clients who have difficulty in chewing or swallowing, have conditions involving the GI tract	Teas, coffee, pudding cooked cereals, eggs, custards, soups, cottage cheese, crackers, toast, fish, chicken, juices, cooked fruit, milk, cream, butter	Corn, pork, raw fruits & vegetables, fried foods, coarse cereals, spices, gas forming foods (onions, cabbage, beans), rich pastry, foods high in roughage
Bland	Foods mild in flavor and easy to digest: omits spicy foods	Avoids irritation of the digestive tract, as with ulcer and colitis clients	Puddings, creamed dishes, milk, eggs, plain potatoes	Fried foods, raw vegetables or fruit, whole-grain products
Low residue	Foods low in bulk: omits foods difficult to digest	Spares the lower digestive tract, as with clients having rectal diseases		Whole-grain products, uncooked fruits and vegetables, avoid food with seeds or skins
High calorie	Foods high in protein, minerals, and vitamins	For underweight or malnourished clients	Eggnog, ice cream, frequent snacks, peanut butter, milk	
Low calorie	Low in cream, butter, cereals, desserts and fats	For clients who should lose weight	Skim milk, fresh fruit and vegetables lean meat, fish	Fried foods, sauces, gravies, rich desserts
Diabetic	Balance of carbohydrates, protein, and fats, devised according to the needs of individual clients	For diabetic clients: matches food intake with the insulin and nutritional requirements*	Fresh fruits and vegetables, low-sugar products	High-sugar foods, alcohol, carbonated beverages

Type of Diet	Description	Common Purpose	Foods Often Recommended	Foods to Avoid
High protein	Meals supplemented with high protein foods, such as meat, fish, cheese, milk, and eggs	Assists in the growth and repair of tissues wasted by disease	Milk, meat, eggs, cheese, fish	
Low fat	Limited amounts of butter, cream, fats and eggs	For clients who have difficulty digesting fats as in gallbladder, cardiovaslar, and liver disturbances	Veal, poultry, fish skin milk, fresh fruits and vegetables	Bacon, butter, cheese fried foods, liver, whole milk, ice cream, chocolate
Low cholesterol	Low in eggs, whole milk, and meats	Helps regulate the amount of cholesterol in the blood	Fruits, vegetables, cereals, grains, nuts, vegetable oil	Brains, organ meats
Low Sodium (Salt)	Limited amount of foods containing sodium; no salt allowed at the table	For clients whose circulation would be impaired by fluid retention; with certain heart or kidney conditions	Puffed wheat/rice or shredded wheat, fruits, fruits juices	Canned vegetables, ham, luncheon meats, frankfurters, most cheeses
Salt-free	Completely without salt		Most fresh or frozen vegetables	

*NOTE: Diabetic Exchange List

It excludes sugar or high sugar content foods to prevent rapid swings in blood sugar. It divides foods into six groups and allows equivalent exchanges to be made within a group but not from group to group. The six groups are:

Milk Exchanges
Vegetable Exchange
  Group A
  Group B

Fruit Exchange
Bread Exchange
Meat Exchange
Fat Exchange

Chemotherapy and Radiation

Many people who are receiving chemotherapy and radiation therapy change their eating habits due to periods of nausea, vomiting, appetite loss, and/or constipation. The best possible diet needs to be planned, taking nutrients from the four food groups and the minerals and vitamins. Here are some helpful hints.

1. Decrease intake of red meats; many people prefer fish, chicken, turkey, and other foods high in protein.
2. Use plastic utensils, as some people complain of a bitter taste from metal utensils.
3. Maintain adequate fluid intake of cook, clear liquids. Set a goal each day and drink before or after meals.
4. Eat small, frequent meals; chew food well; eat warm, not hot food.
5. Decrease intake of sweets and fried or fatty foods; this will decrease nausea and decrease intake of empty calories.
6. Remain in a sitting position for 2 hours after meals.
7. Eat non-gas-producing foods.
8. Fiber may or may not be tolerated.
9. Provide a pleasant, quiet atmosphere.
10. Vary the diet.
11. If the client has difficulty eating by him/herself or being neat as he/she eats, protect his/her clothes without making him/her feel like an infant.

Special Diets

Special diets are planned to meet specific patient needs. Patients may need special diets because of religious preferences or health needs.

RELIGIOUS RESTRICTIONS: Religious practice requires changed in diet for some patients. For example, persons of the conservative Jewish faith have strict food laws to be followed.

> There are strict prohibitions against shellfish and nonkosher meats such as pork.
>
> Certain fish such as tuna and salmon are permitted.
>
> Foods may not be prepared in utensils that have been used for nonkosher food preparation

In addition, the Jewish Orthodox faith:

> forbids the serving of milk and milk products with meat.
> observes specific fast days.

Preparing Patients for Mealtime

Eating should be an enjoyable experience. Prepare the patient for his/her tray before it arrives by:

1. offering the bedpan.
2. assisting patient to wash hands and face.
3. assisting with oral hygiene.

4. being sure lighting is adequate for patient to see food. (Give patient eyeglasses if he/she wears them.)
5. raising head of bed, if permitted.
6. assisting patient out of bed and into a chair, if permitted.
7. adjusting the in-bed patient's position with pillows.
8. clearing away anything that is unpleasant, such as emesis basin and bedpan.
9. clearing the over-bed table.
10. allowing the patient to do as much as possible for him/herself.
11. obtaining the tray and checking against patient's identification band.

When you have served the tray and after you have washed your hands, assist the patient as needed by:

1. being unhurried and pleasant.
2. opening pre-packaged items.
3. cutting meat.
4. pouring liquids.
5. buttering bread.
6. explaining the arrangement of the tray as items related to the face of a clock if patient cannot see.

After removing tray:

1. note how much the patient has eaten and how much he has had to drink.
2. record the intake for those patients who are on intake and output on the intake and output sheet.

Help patient back to bed.

1. If the patient ate in bed, brush crumbs from the bed, smooth out the sheets, and straighten the bedding.
2. Make the patient comfortable.
3. Lower the bed to a position of safety for the patient.
4. Pull the curtains back to the open position.
5. Raise the side rails where ordered, indicated, and appropriate for patient safety.
6. Place the call light within easy reach of the patient.
7. Wash your hands.

Assisting to Feed a Helpless Patient

Preparations before mealtime are the same for the helpless patient who cannot feed him/herself. Be observant throughout. Watch for signs of choking or anything unusual.

1. Sit to feed the patient. Face patient so he/she sees you and food.
2. Adjust patient to a comfortable position.
3. Place napkin under patient's chin.
4. Obtain tray and check against patient's identification band.
5. Place tray on over-bed table within patient's range of vision.
6. Butter bread and cut meat. Do not pour hot beverage until patient is ready for it.
7. Use drinking straw to give cold fluids.

8. Hold spoon at a right angle:
   a. give solid foods from point of spoon (fill spoon half full).
   b. alternate solids and liquids.
   c. If a patient is paralyzed on one side of his/her body, make sure you feed him/her on the side of his/her mouth that is not paralyzed.
   d. rotate the offerings of food.
   e. describe or show patient what kind of food you are giving her.
   f. test hot foods by dropping a small amount on the inside of your wrist before feeding them to the patient.
9. Season food the way the patient likes it only if the request agrees with the prescribed diet.
10. Never blow on the patient's food to cool it.
11. Never taste the patient's food.
12. Avoid hitting the teeth with the utensil.

Feed the patient slowly. Remember that he/she may chew and swallow very slowly. Allow plenty of time between mouthfuls. Encourage the patient to finish his/her meal, but do not force him.

When the patient has finished eating, help him to wipe his/her mouth with the napkin or do this for him/her. Record how much the patient has eaten and how much h/she has had to drink (I/O) and how the patient tolerated the diet.

Safety Factors

Be sure a client is able to swallow before you put food in his/her mouth. Some clients will be able to swallow one food and not another. Pay special attention to the temperature of food. If a food is hot, tell the client and then offer him/her a small amount. If the food is cold, do the same. When offering a glass or a cup, first touch it to the lips.

Supplementary Nourishments

Between meal nourishments are usually served:
Midmorning: 9:30-10:00 a.m.
Mid afternoon: 2:30-3:00 p.m.
At bedtime: 8:00-10:00 p.m.

Snacks served include:
milk
juices
gelatin
crackers
custard
ice cream
sherbet
sandwich

Patients are often given extra nourishment as part of their medical care. Some patients on diets are allowed to have only certain kinds and amounts of extra nourishment. Other patients may not be allowed to have anything at all.

In some institutions, extra nourishment is passed out to patients by workers from the food service department. However, you may be assigned this responsibility. If you are, the head nurse or your team leader will give you a list of patients that will show:

a. those who are not to be given anything.
b. those who are allowed to have certain nourishment, such as skin milk or tea.
c. those who have no restrictions on their diet.

Fluid Intake

It is important to provide fresh water for patients. In all cases you should know whether a patient is allowed ice or tap water or is NPO (not to have anything to drink or eat). Even without an order to force fluids you must encourage patients to take 6-8 glasses of fluid daily. Give special attention to confused patients and patients who may be removed from a source of water. Because patients do not drink enough water, sometimes the physician will leave orders that fluids are to be forced to a specific number of cc per day.

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INTRODUCTION TO NURSING
Skin Assessment

I. Skin Assessment--View MED 111 "Assessment of Skin, Hair and Nails" (30 min.)

   A. Examination methods

      1. inspect

      2. palpate

   B. Compare to norms

   C. Skin care practices: factors influencing

   D. Clients at risk

      1. alteration in nutritional status

      2. immobility

      3. altered hydration

      4. altered sensation

      5. presence of secretions or excretions on skin

      6. mechanical devices

      7. altered venous circulation

II. Identification of Problems

   A. Planning

   B. Nursing intervention

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INTRODUCTION TO NURSING - SECTION II
Assessment of Urinary Elimination

- I. Fluid intake/output
- II. Urine
  - A. Volume/amount
  - B. Color
  - C. Clarity
  - D. Odor
- III. Void Pattern
  - A. Frequency
  - B. Urgency
  - C. Dysuria
  - D. Incontinence
    - 1. total
    - 2. stress
    - 3. overflow
    - 4. nocturia
    - 5. dribbling
  - E. Retention
    - 1. total
    - 2. overflow
- IV. Correlated Factors
  - A. Temperature
  - B. History of urinary tract infection (UTI)
  - C. Medication effects, especially diuretics (water pills), cholinergic, antidepressants
  - D. Skin integrity, perineal area
- V. Diagnostic Tests
  - A. CBC
  - B. Urine
- VI. Influencing Data Associated with Older Adults
  - A. Related illness/surgeries
    - 1. urinary
    - 2. bowel
    - 3. infections in pelvic area
    - 4. catheter
  - B. Physical activity/mobility
    - 1. slow gait
    - 2. insecure balance
    - 3. transfer capability
    - 4. visual impairments affecting movements
  - C. Mental status, cognitive deficits
    - 1. abilities to be aware of bladder cues
    - 2. orientation or ability to use commode or toilet
  - D. Food/fluid intake schedule in relationship to activity and sleep pattern
  - E. Clothing
    - 1. removal ease and/or protective coverings

- F. Environment
    - 1. distance to bathroom
    - 2. another using toilet
- G. Social activities
    - 1. assistance needed to maintain control limits of participation
- H. Assistance needed to maintain normal voiding pattern
    - 1. toileting
    - 2. privacy
    - 3. maintaining normal bowel elimination

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INTRODUCTION TO NURSING - SECTION II
Wound Assessment - Chapter 45

I. Clinical Assessment - use visual inspection, palpation, sense, smell

A. Appearance - sequential signs of healing

1. no bleeding; clot binding edges together

2. inflammation at edges (1-3 days)

3. reduction in inflammation when clot diminishes

4. scar formation

5. diminished scar

B. Drainage

1. location

2. type

3. amount

C. Swelling

D. Odor

E. Dehiscence

F. Pain

II. Lab Data

A. Deficient leukocytes

B. Prolonged coagulation time

C. Serum protein analysis

D. Decreased hbg and hct

E. Wound culture

III. Planning - independent and dependent nursing strategies

A. Preventing infection

B. Preventing further tissue damage

C. Promoting healing

D. Cleaning wounds of foreign debris

E. Promoting drainage

F. Preventing hemorrhage

G. Preventing skin excoriation around draining wounds

IV. Interventions

A. Care of open vs. closed wounds

B. Support and immobilization

C. Heat and cold therapy

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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I
Legal/Ethical Issues

Objectives: After discussion of legal/ethical issues, the student will be able to:

1. describe ethical behavior.
2. describe legal responsibilities of nurses.
3. identify the kind of information that is considered to be confidential.
4. demonstrate tactful refusal of a tip offered by a patient.
5. work accurately and be dependable.
6. give examples of accountability, dependability, negligence, libel, slander, false imprisonment, assault and battery, invasion of privacy.
7. identify patient's rights and nurse's basic rights.

ETHICS

I. Ethics is important in nursing because of the nurse's complex role and responsibilities to self, client, health care team, and society.

II. Ethics is the principles or standards that are set up to govern behavior.

III. As a profession, nursing has a code of ethics and is characterized by responsibility and accountability.

   A. Nursing's code of ethics provides minimal standards of behavior and principles for making ethical decisions related to client care.

   B. Nurses are responsible for carrying out specific nursing activities properly and competently and are accountable to the self, client, profession, employing agency, and society for their actions.

      1. The nurse's primary ethical concern is to assist the client in receiving quality health care.

      2. The many responsibilities of the nurse often result in ethical conflicts the nurse must work to resolve.

      3. Professional accountability is important for evaluating practices, maintaining standards of care, enhancing personal growth and awareness, and providing a basis for ethical decision making.

IV. Client advocacy is an important ethical concern in nursing.

   A. Client advocacy involves informing and supporting the client's right to self-determination.

B. Client advocacy requires the nurse to keep an open mind and accept the client's values and beliefs even when they are different.

C. Client advocacy is **NOT** giving clients advice in decisions but assisting them in making their own decisions.

Code of Ethics

Ethical behavior means keeping your promises and doing what you ought to do. You should observe the following code for ethical behavior.

1. Be conscientious in the performance of your duties. This means do the best you can.
2. Perform all your duties in a spirit of cooperation and follow orders willingly.
3. Report tot he head nurse or team leader whenever you leave the unit for any purpose and at the end of your shift. Report to her/him again when you return.
4. Take all questions you may have about patients and their care to your head nurse or team leader.
5. Accept jobs assigned to you without complaint
6. Follow the advice of your supervisors.
7. Show a willingness to learn.
8. Respect the right of all patients to beliefs and opinions that might be different from yours.
9. Let the patient know that it is your pleasure, not just your job, to assist him/her.
10. Do only those things that you have been taught and that are within the scope of your training.
11. Keep your skills and knowledge up to date.
12. Act in ways that keep the safety and well-being of the patient always foremost in your mind.
13. Make sure you thoroughly understand directions for the care you are to give. If you do not understand something, ask your supervisor.
14. Report accidents or errors immediately to the team leader or head nurse.
15. Be accuracy to the best of your ability.
16. Perform you job according to facility policy.
17. Do no harm to the patient and/or his/her belongings.
18. Do not discuss personal problems with clients.
19. Do not discuss your clients with your friends, relatives, fellow workers, except when in conference, news media, relatives and friends of client or to one client about another client. (Ethic of Confidentiality)
20. Honor the responsibility of the agency that employs you.
21. Report all complaints from patients and visitors to the head nurse or team leader. Never ignore complaints, no matter how silly or unreasonable they may seem to you.
22. Do not waste supplies or equipment.
23. Be ready to adjust quickly to new situations.
24. Being dependable means:
    a) reporting to work on time.
    b) keeping absences or a minimum.
    c) keeping promises.

- d) doing assigned task as well as you can and finishing it quickly, quietly and efficiently
- e) performing a task you know should be done without having to be told.

Tipping

Following the ethical code, the service you give will depend on need. It will not depend upon the patient's race, creed, color, or ability to pay. There is no place for tipping within this system. Patients are charged for the services they receive while in the hospital. The salary you are paid is included in that charge.

Sometimes patients offer a "little something" to you. A firm but courteous refusal of the money is usually all that is necessary to assure the patient of your meaning. Small gifts may, however, be accepted. Report these to your supervisor for your own protection.

Negligence/Malpractice

Laws concerning patients and workers in health care institutions were written to protect both the patient and the worker. You need to understand how the law affects you and the patients you care for. Patients are entitled to respect for their human rights. They must be kept safe and must be cared for properly.

The words negligence and malpractice are often used interchangeably, as if they were the same thing. Officially, negligence is the commission of an act or failure to perform an act where the respective performance or nonperformance deviates from the act that should have been done by a reasonably prudent person under the same or similar conditions. Malpractice is negligence when applied to the performance of a professional. Examples are:

1. failing to fasten the safety strap over a patient on a stretcher and as a result the patient falls. (Nursing Assistant is guilty of negligence.)
2. performing procedures not included in his/her job description or for which s/he has not been trained or performs any procedure incorrectly. (Guilty of negligence.)
3. serving a regular diet to a diabetic patient. (Guilty of negligence.)
4. neglecting to wash his/her hands before or after contact with a patient. (Guilty of negligence.)
5. not carrying out your job in a conscientious manner. For example, though your facility has a policy that bed rails must be up a tonight, in your hurry you forget to secure the bed rails and the patient falls and is injured.

Theft

Taking anything that doesn't belong to you makes you guilty of stealing. If you are caught, you will be legally liable. The article taken need not be expensive to be considered stolen.

If you see someone stealing something and do not report it, you are guilty of aid and abetting the crime.

Libel/Slander

If you make false statements about another to a third person and the character of the first person is injured, you are guilty of defamation. This is true if you make the statement verbally (**slander**) or in writing (**libel**). For example, if you inaccurately tell a coworker that a patient has AIDS, you have slandered that individual. If you write the same untrue information in a note, you are guilty of libel.

False Imprisonment

Restraining a person's movements or actions without proper authorization constitutes unlawful imprisonment. For example, patients have the right to leave the hospital **with** or **without** the physician's permission. You may not interfere with this right. If you do interfere, you will be guilty of false imprisonment.

Make sure if you learn of a patient's intention to leave without permission that you inform the supervisor. The supervisor will handle the situation.

Using physical restraints or even threatening to do so in order to make a patient cooperate can also constitute false imprisonment. It is sometimes necessary to restrain the movement of patients. Whenever used, restraints must always be applied in accordance with a specific physician's order. The physician's order indicates the extent of restraint to be used the reason for it.

Restraints are only applied for the purpose of protecting the patient or to protect others from the patient. To avoid a charge of false imprisonment when using restraints, the health care assistant must be very careful to:

1. never apply or remove restraints on her/his own initiative.
2. more frequently observe and care for any patient who is restrained.
3. check restraints and restraint sites frequently.
4. report signs of irritation or circulatory impairment immediately to the nurse.

Assault and Battery

Assault and battery are serious legal matters. **Assault** means intentionally attempting to touch the body of another or even threatening to do so. **Battery** means actually touching another without that person's permission.

The care we give is given with the patient's permission or **informed consent**. This means the patient must know and agree to what we plan to do before we start. Consent may be withdrawn at any time. For example, you are assigned to give a patient a warm foot soak. Despite your explanation of the reasons for the order, the patient refuses. YOu may not force the patient to submit. To do so would make you guilty of batter. To threaten the patient by telling her/him that you will get others to assist you if s/he refuses is to be guilty of assault.

Either situation could make you liable for legal charges. You can avoid this legal pitfall by:

1. informing the patient of what you plan to do.
2. making sure the patient understands.
3. pausing before starting to give the patient an opportunity to refuse.
4. reporting refusals of care to the supervisor and documenting the facts.
5. never carrying out a treatment on your own against the patient's wishes.

Invasion of Privacy

Patient has a right to have their person and personal affairs kept confidential. To do otherwise is an **invasion of privacy**. Invading the privacy of another is against the law.

You can protect the patient's privacy by:

1. not exposing the patient's body unnecessarily.
2. knocking and pausing before entering a room.
3. drawing curtains when carrying out care.
4. leaving while visitors are with the patient.
5. not eavesdropping as patients make telephone calls.
6. abiding by the rules of confidentiality.
7. not trying to force a patient to accept your personal beliefs or views.

Resident Rights

Resident rights are preserved when nurses use skills which protect the resident's basic constitutional rights.

1. Recognize the resident's right to quality care regardless of race, color, ethnic origin, age, special favors, religion, marital status, sexual preference, or handicap.

2. Encourage and support resident in making personal choices to accommodate individual needs in all areas of daily life.

3. Provide privacy for the resident (knocking on door and waiting for answer, screening, bath blankets, lap robes, etc.) during procedures and when desired.

4. Maintain confidentiality of resident (mail, phone calls, information disclosures, medical record, visitors, etc.)

5. Address resident by the name resident prefers to be called.

6. Assist the resident to safeguard personal possessions.

7. Provide care to the resident which is free from abuse, mistreatment, or neglect.

8. Report any instances of neglect, abuse, or mistreatment of resident to appropriate facility staff.

9. Assist resident as desired in personal communication (writing letters, making phone calls, etc.)
10. Recognize the resident's right to resolve grievances and refer the resident and/or resident's family to the available resources.
11. Assist resident as needed to exercise citizenship rights.

Nurses' Rights

Rights of nurses include the following.

1. Rights as a citizen; such as respect for individual freedom of choice, equality and professional rights.
2. Right to have safe and functional equipment and services. Equipment must be sufficient to perform her/his work. Work environment must be safe with minimal physical and emotional stress. Stressors such as potentially infectious microorganisms must be identified and suitable precautions must be taken to protect health of nurses and other health care workers.
3. Right to compensation for services.
4. Right to competent assistance (including pharmacists, dietitians, inhalation therapists, etc.)

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INTRODUCTION TO NURSING - SECTION I
RELATIONSHIPS

Objectives:

After discussion of content on supportive relationships, the student will be able to:

1. identify supportive and non-supportive behavior of the nurse in nurse-patient situations.
2. identify empathy and give examples of empathy in nursing and non-nursing relationships.
3. give an example of actual and perceived inappropriate touching in a nurse-patient relationship.
4. give an example of a patient's difficult or combative behavior and the appropriate response of the nurse.

Emotionally Stressed Maladaptive Behavior:

Patients may say things to you that they would not say to their relatives. They may use unpleasant or nasty, **abusive** words. Why? You are not a family member and therefore you do not have all the years of family relationship behind you. Since you are paid to care for the client, s/he may feel that you will return even if s/he isn't nice because it is "your job". A visiting family member doesn't have to care for the patient and if the patient is unpleasant, the family member may not return. Some patients may say and do things to test you and the limits of the situation. Often patients will be very nice to you but not to their families. This is to make the family jealous and show them that s/he is still in control of his/her situation. S/He can still make people feel good or hurt their feelings. Some patients do or say unpleasant things, but are not aware that their behavior is a problem to anyone. If you tell the patient that something s/he does makes you uncomfortable, s/he will often stop it. Working with a patient who is unpleasant to you is very difficult. Remember that there is a **reason** for such behavior. Discuss the entire situation with the supervisor and she will assist you in dealing with it.

Confusion (Delirium)

Physical ailments and stresses that can bring about a confused state include:

1. pneumonia
2. myocardial infarction
3. renal infection
4. head trauma
5. organic brain disease
6. fevers
7. dehydration
8. drug interaction

Confusion can also result following surgery.

List A
Signs and Symptoms of Confusion

*Inability to think clearly and quickly
*Bewilderment
*Faulty memory
*Drowsiness during the day and agitation during the night
*Alternating periods of excitability and drowsiness
*Disorientation
*Inability to follow directions
*Misinterpretation of stimuli

List B
Reality-orientation Activities

*Keep glasses, dentures, and hearing aids in place
*Speak often with the patient
*Identify yourself to the patient each time there is contact
*Be patient and repeat instructions
*Keep clock and calendar in view
*Encourage the presence of and refer to familiar objects
*Post activity board and draw attention to it
*Call attention to color coding of facility areas

The confused person cannot be responsible for his/her own actions or for protecting him/herself adequately. The patient's sensory misinterpretations (delusions or hallucinations) may put others at risk. Protection of the patient is the most important nursing responsibility. In addition, you should:

1. be calm and gentle in approaching the patient since confused patients are startled by even minor stimuli.
2. give instructions slowly, clearly, and in simple words.
3. give only one instruction at a time.
4. provide activities of short length that do not require strong concentration.
5. build the patient's self-esteem with the reward of positive comments.
6. assist patients to participate in reality-orientation activities (List B).
7. maintain a constant, limited routine.
8. use restraints only when absolutely necessary and with a physician's order, making sure all safety practices are followed.

Agitation

Agitation is defined as inappropriate verbal, vocal, or motor activity due to causes other than confusion or real need. It includes behavior such as:

*aimless wandering
*pacing
*cursing
*screaming
*repeatedly asking the same question
*spitting
*biting
*fighting constantly
*demanding attention

Agitation is a significant problem for the elderly, their families, and the nursing staff. It is probably one of the foremost management problems in acute-care hospitals, in home care, and in long-term care.

The major factors contributing to agitation are listed in List C. Study the list carefully because your awareness can lead to early intervention. Early intervention can often prevent serious problems.

List C
Factors Contributing to Agitation

*Frustration at loss of control
*Feelings that their space has been invaded
*Loneliness and need for attention
*Unresolved personal difficulties in their past
*Drug interactions
*Boredom
*Behavior of others around them
*Depression
*Dehydration
*Constipation
*Restraints

The best way to manage the agitated patient is to:

1. not argue with or confront the person.
2. make the environment safe (secure the windows and lock the doors).
3. make sure each patient wears an identification bracelet or "patch", which is fastened securely.
4. keep a recent photo of the patient in the event the patient wanders off.
5. notify the physician, the administrator, the family, or the police department if the patient wanders away from his/her unit or facility or home.
6. assign the patient brief tasks.
7. engage the patient in games, walks, swimming, and other activities if not contraindicated. These should be activities that enhance the patient's self-esteem.
8. use bean-bag seats and rocking chairs in the parlors of the nursing home or the patient's home.
9. care of the patient: watch for injuries.
10. engage the patient in conversations and in reality therapy or remotivation groups.
11. engage the patient in short-term activities. Realize that the patient's attention span is short and s/he needs rewards for short-term activities.
12. prevent the patient from becoming exhausted.
13. carefully monitor the patient's activities since the agitated patient is at risk for falls and injuries.

Paranoia

Paranoia is another extreme maladaptive response to stress. A person with paranoia will believe that everyone is against her. When caring for the paranoid patient, you should:

1. find ways to reduce the patient's feelings of insecurity and misunderstanding.
2. keep the person as involved as possible in reality activities.
3. report any unusual behavior.
4. monitor nutrition and fluid balance since these patients often refuse to eat or drink for fear of poisoning.
5. observe sleep patterns since the person may be fearful of being harmed while sleeping.
6. be direct and honest in all interactions.
7. not support any misconceptions of delusions that the person exhibits.

Touch

The intimate nature of many nursing tasks requires that caring be transmitted by touch. The ability to reach out and touch a patient may be more common in some cultures than in others. Although a nurse may prefer to know the person better before touching him/her, the nature of many short-term nursing interactions preclude lengthy introductions.

In one study, hospital patients receiving spontaneous touch from nurses perceived that the nurses showed genuine interest in them within a short time. Touch may intrude as well as soothe, and the observant nurse decides how and when to touch based on each patient's response. Any unnecessary stroking, fondling of the patient's body are threatening touches and intrusions into patient's personal space.

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INTRODUCTION TO NURSING - SECTION II
Patient Case Study

Mrs. Mary Gates is an 82-year-old woman who was admitted to a long-term care facility last week. She wears glasses and hearing aid and has upper and lower dentures. She walks with assistance with a walker. The main diagnosis upon her admission was hemiparesis due to rt CVA, degenerative osteoarthritis and dementia. Mrs. Gate's daughter states that her mother has become mentally confused lately and has difficulty remembering. One year ago Mrs. Gates suffered a stroke.

She was recently treated for an urinary tract infection with Erythromycin. More recently she has problems with urinary and bowel incontinence. She complains of rectal discomfort due to hemorrhoids and constipation. Her daughter states that within the last year her mother's activity level has decreased. Most of the day was spent preparing meals and doing simple household chores. Now Mrs. Gates spends most of her time sitting or sleeping. Recent lab results on urinalysis indicate few leukocytes, with some bacteria and slightly alkaline. Urine sample was concentrated with mucous shreds.

Mrs. Gates walking tolerance is minimal as is her activity tolerance. Her skin is dry and has an odoriferous reddened peri-area. Food intake is fair; she drinks small amount of fluids at meal times. She is on a diuretic (water pill) daily. She prefers to spend more time alone in her room.

1. Assess Mrs. Gates urinary elimination.
2. Identify potential or actual urinary elimination problems.
3. List specific nursing measures to be incorporated into patient care and to prevent or alleviate the patient's urinary problems.

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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I

Safety Assessment

Assignment:

Read Kozier, Erb & Bufalino, Chapter 24 "Providing a Safe Environment

Do a Safety Assessment on your family and home.

1. Look at factors such as age, life style, etc. and identify those that might put you and members of your family at risk for accidents/injuries.

2. Look at the environment and identify potential hazards (falls, fire, poison, electrical, etc.).

3. Identify ways to prevent injury/accidents by:

    a. educating your family about prevention.

    b. modifying the environment to make it safe.

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EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

Name ______________________________

INTRODUCTION TO NURSING - SECTION I
Bowel and Urine Elimination Work Sheet

1. What are two factors that affect defecation?

2. List Characteristics of Normal Feces.

Characteristic	Normal
Color	
Consistency	
Odor	
Frequency	
Shape	
Amount	

3. Why is the normal color of feces brown?

4. What may a black tarry feces indicate?

5. What may a clay-colored (acholic) feces indicate?

6. What may a green or orange stool indicate?

7. John had beets for lunch. His stool may be ________________ or ________________ in color.

8. Jane takes ferrous sulfate for her anemia. Her stools may be ____________________________ in color.

9. Water feces indicate:

10. Hard stools indicate:

11. Feces are normally the shape of the rectum. What might a string like stool indicate?

12. Normal odor of feces results from:

13. A putrid odor may indicate a:

14. What is occult blood?

15. Identify five (5) common fecal elimination problems and the causes of each.

16. List Characteristics of Normal Urine.

Characteristic	Normal
Amount in 24 hours (adult)	
Color	
Consistency	
Odor	
Sterility	
pH	
Specific gravity	
Glucose	
Ketone bodies (acetone)	
Blood	

17. Where is urine formed?

18. What is the reservoir for urine?

19. How much urine does the bladder normally contain before an adult experiences the desire to void?

20. Describe 5 urinary elimination problems and the causes of each.

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CHIPPEWA VALLEY TECHNICAL COLLEGE
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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION I

I. Mobility and Immobility

- A. Concepts related to mobility
    - 1. mobility: the ability to move freely and purposefully in h environment and is an essential part of living
    - 2. immobility: restriction of movement in any area of a person's life, affects almost every body organ and system adversely - physiologic functioning, self esteem, body image
    - 3. physical fitness - state of purposeful active physical conditioning
- B. Factors affecting mobility
    - 1. lifestyle
    - 2. disability
    - 3. energy level
    - 4. age
- C. Reasons for immobility
    - 1. therapeutic restriction to movement
    - 2. primary disability
    - 3. voluntary restriction
- D. Degrees of immobility ---------> bedrest "complete"
- E. Benefits of immobility
    - 1. reduce pain
    - 2. directs energy toward healing
    - 3. decreased activity, decreased metabolism, decreased need of cells for oxygen
- F. Mobility and immobility - what to observe
    - 1. body alignment
    - 2. body mechanics
    - 3. ambulation

4. ROM - joint mobility
    a. degree of movement
    b. discomfort
    c. joint swelling or redness
    d. muscle development
    e. client's tolerance
5. ADLs - activities of daily living
6. Physical fitness
    a. cardiorespiratory endurance
    b. muscular strength - endurance
    c. joint flexibility
    d. body weight - composition
    e. motor skill performance
7. Activity tolerance

G. Responses to immobility
1. degree of change depends on risk factors
    a. large body area is immobilized
    b. immobilization lasts a long time
    c. client is elderly
    d. client experiences pain or muscle spasms
    e. sensitivity to temp, pain, pressure decreased
    f. poorly nourished client
    g. unable to learn how to prevent problems
    h. immobility in one position for long period
2. physiologic - psychosocial responses

a. musculoskeletal changes	observations	nursing intervention
decreased muscle strength due to muscle atrophy		
contractures		

b. cardiovascular changes	observations	nursing intervention
increased heart rate		
orthostatic hypotension		
incompetent valves (leg veins)		

c. respiratory changes	observations	nursing intervention
altered lung ventilation		
pneumonia		

d. metabolic and nutritional changes	observations	nursing intervention
reduced gastro-intestinal motility		
anorexia		
negative calcium balance		

e. urinary and endocrine changes	observations	nursing intervention
urinary stasis - stones		
reflux - infection		

f. bowel elimination changes - covered elsewhere
g. integumentary changes - covered elsewhere

h. neurosensory changes	observations	nursing intervention
confusion		
irritation		

i. psychosocial changes	observations	nursing intervention
depression		
anxiety		
low self-concept		

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INTRODUCTION TO NURSING - SECTION II

Ageism: a dislike of aging and older people based on the belief that aging makes people unattractive, unintelligent and unemployable.

Societal Disengagement: when society withdraws support from the individual group and prevents the individual or group from becoming involved.

Self-fulfilling Prophecy: negative attitudes toward aging give individuals negative expectations and the end result is that individuals live out those negativisms.

Gerontology: the organized study of the causes and consequences of aging and old age.

Theories of Aging

Genetic Theory: aging results from biochemical changes programmed into the DNA molecule in each cell.

Autoimmune: the production of autoimmune antibodies increases and they attack the body cells.

Stress Theory: aging results from cellular loss due to wear and tear on the body. Regeneration of body tissues eventually cannot keep pace with the wear and tear and the body is unable to maintain a stable internal environment.

Program Theory: the organism is capable of a predetermined number of cell divisions, after which the cells die.

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CHIPPEWA VALLEY TECHNICAL COLLEGE
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INTRODUCTION TO NURSING
Case Study

Mrs. Sanyos is a 67-year-old Mexican woman who was brought to the Emergency Room by her daughter. Mrs. Sanyos states she is very tired while clutching her left hand to her chest. She does not appear to have difficulty breathing although she states she has difficulty breathing at times. She appears anxious and fatigued. When the nurse states "you look tired", Mrs. Sanyos answered, "I am tired because I don't sleep well at night when I can't get my breath." Mrs. Sanyos' TPR 98.2-88-22, BP 152/94. Skin color of extremities--pink, no evidence of edema. Normal chest sounds. Mrs. Sanyos does not appear to be in immediate distress, although she is teary-eyed.

You are the nurse caring for Mrs. Sanyos in the Emergency Room. You are given 15 minutes to assess the patient's health problem and the etiology. How would you proceed with the interview? Write your interventions (using the exact words). Your goal is to identify the patient's health problem using the least amount of time with the fewest interactions.

NURSE:

MRS. SANYOS:

NURSE:

MRS. SANYOS:

NURSE

MRS. SANYOS:

NURSE:

MRS. SANYOS:

NURSE:

MRS. SANYOS:

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Problem-Solving Process	Nursing Process	Scientific Method
1. Encounter a problem	1. Assessing	1. Recognize and define the problem
2. Collect data	2. Diagnosing	2. Collect data from observation and experiments
3. Analyze info and identify exact nature of the problem	3. Planning	3. Formulate hypothesis
4. Determine plan of action	4. Implementing	4. Select plan to test hypothesis
5. Carry out plan	5. Evaluating	5. Test hypothesis
6. Evaluate plan and its outcomes		6. Interpret test results and if hyposis is correct
7. Terminate or modify the plan		7. Conclude or modify hypothesis

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ITN/CaseStdy.F89

MRS. SANYOS CASE STUDY

NURSE: Mrs. Sanyos, your BP is normal and resp too, but you seem upset. Can you tell me about what is troubling you?

MRS. SANYOS: My heart is so heavy. It hurts and then I can't breathe.

NURSE: Can you tell me more about this? When did this begin?

MRS. SANYOS: Three weeks ago.

NURSE: Mrs. Sanyos, has anything different happened 3 weeks ago that has changed the way you feel?

MRS. SANYOS: (Becomes teary-eyed and starts to cry) My husband has cancer. He is in the hospital.

NURSE: Is three weeks ago the time when you were told about your husband's cancer?

MRS. SANYOS: Yes and then he got weak and the doctor put him in the hospital.

NURSE: Is this when you started feeling sad and had problems breathing and sleeping?

MRS. SANYOS: Yes.

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INTRODUCTION TO NURSING
Clinical Experience Record

Name ______________________________________ Date __________________

Clinical Initials ________ Age ________ Room Number __________

Medical DX

Treatments/Procedures (Performed or Observed)

Pertinent Observations (Psychosocial, Cultural, Biological and Developmental)

Priority Nursing Problems

Actions I was pleased about (your own actions)

Actions I'd like to improve (your own actions)

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CHIPPEWA VALLEY TECHNICAL COLLEGE
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ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING
Fall, 1989

Mrs. Grace is a 76-year-old woman who was admitted to long-term nursing facility after suffering a stroke (CVA) three weeks ago. She has a history of hypertension. She has residual weakness of her right arm and leg as a result of the stroke. She drools and at times cries often and asks for her daughter who live in a small community three hours away. Her daughter visits her mother weekly. Mrs. Grace's role in the home was caring for her children and helping her husband on the farm. Her husband passed away six months ago. Mrs. Grace and her husband were active members in their church.

Class Activity

1. Identify Mrs. Grace's needs according to Maslow's hierarchy of needs.

2. What factors will impact on Mrs. Grace's ability to meet her needs?

3. How might the nurse intervene to assist Mrs. Grace in meeting her needs?

EW/8-89/bh
ITN/ClsActiv.F89

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING
Communication

Objectives:

After discussion of content on Communication, you will be able to:

1. Give examples of courteous and professional behavior that should be exhibited toward patient's visitors and coworkers.
2. Communicate tactfully and keep emotions under control in difficult situations.
3. Identify what you could say to patients to communicate interest and concern.
4. Use communication skills effectively when relating to patients and their visitors.
5. Identify rights that every patient has.
6. Identify common barriers to effective communication.
7. Identify differences between assertive, aggressive and passive responses.
8. Define communication, body language, courtesy, empathy and tact.

Definitions:

Communication: The exchange of thoughts, messages or ideas by speech, signals, gestures, or writing.

Body Language (nonverbal behavior): Communication through hand movements (gestures, facial expressions, body movements, and touch).

Courtesy: Being polite and considerate.

Empathy: When feelings, thoughts and motives of one person are understood and/or felt by another person without pity.

Tact: Doing and saying the right things at the right time.

Patient's Bill of Rights (American Hospital Association):

Every patient has:

1. The right to considerate and respectful care.
2. The right to understandable, complete, and current information form the doctor about the diagnosis, the treatments that will be used their risks and benefits, how long the sickness is likely to last, and the prognosis (the likelihood of recovery).
3. The right to refuse to participate in experiments and the right to refuse treatment if local laws allow the patient to refuse. This includes the right to leave a hospital against medical advice if the patient does not think hospital treatment is helping.
4. The right to be told which doctor is mainly in charge of the care, who is usually referred to as the primary physician.
5. The right to privacy; records will be kept confidential, and permission is necessary if anyone who is not directly involved in the treatment is present during the treatment.
6. The right to examine and receive an explanation of a bill regardless of the source of payment.

Relating to People

The relations between yourself and patients, visitors, parents, fellow-workers depend on your approach to them. If you have a kind, courteous, tactful, empathetic and open manner, you will find it easier to form positive relationships. Relationship depend on receiving as well as giving so listening attentively is as important as what you say.

You must possess or develop certain qualities or characteristics if you are to fulfill your role. These qualities will give your patients and coworkers a sense of security, confidence, trust and reliability. Being courteous means putting the needs of others before your own. It means cooperating, sharing and giving. Being polite and considerate of other shows that you care about them.

Emotional Control

Sometimes a patient, another staff member or visitor may upset and anger you. You may feel like making a nasty remark. DON'T! Stop and think! The patient and his/her visitors may be worried, nervous, or tense. Fellow workers may be under stress because of a problem at home or on the job. Try to be understanding and learn to control anger and cope with all situations. Learning to accept constructive criticism and suggestions without feeling you are being attacked is an essential part of your job. Try to avoid becoming defensive. If your supervisor criticizes you or tells you to do something, you may feel like saying, "This is not my job." Examine your attitude. Calm down and then perform the right or correct action.

Relationship with Patients

Always try to give the patient confidence in the hospital, the doctors, and the nursing staff. Never discuss or criticize any of your fellow staff members in front of a patient. Never talk to anyone except your head nurse or team leader about a patient's condition. Discussing one patient's medical condition with another patient is an invasion of privacy. Patients and visitors often relieve feelings of helplessness and hopelessness through words and behavior. Remember that the patient may be suffering emotionally as well as physically; talking may relieve his/her emotional suffering.

Try to be tactful. When a patient begins to recover, give praise and encouragement. This will lift his/her spirits.

Always listen when a patient makes a complaint or brings up a problem. Questions about the doctor or plans for discharge should be referred to the team leader.

Guidelines for Communicating with Patients

1. Show an interest in what the patient is saying.
2. Let your facial expressions show that you are interested.
3. Use good manners.
4. Speak clearly, distinctly and slowly. Speak in a normal, pleasant tone.

5. Use language that the patient can understand.
6. Respect the patient's moods. Sometimes silence can help.
7. Make your body movements look pleasing and energetic.
8. When someone in need asks you for assistance, whether to bathe or turn him/her or to get something that is out of reach, you should give your assistance willingly and graciously, no matter whose assigned patient it is. It helps to have kind thoughts. This will enable you to cope with and handle a situation with kindness.

Nonverbal Communication and Body Language

Every time you touch a person's body, whether you speak any words or not, you are communicating something. How you assist a person in any action that involves touching her/his body says something. If you are careful, firm, and gentle, it tells the person something far different than if you are rough.

Pay attention to your posture. The way you move when you enter a patient's room or how you stand by his/her bed are ways of communicating through body language. Try to make these movements communicate energy, a sense of interest, and a willingness to help. A frown, an impatient body movement, or a shrug may give the patient the message, "Do not bother me." Also a certain way of standing or walking may send the message, "I am lazy" or "I don't want to be bothered."

Look at the patient when you speak to him/her. This tells the patient that s/he has your attention. If you are looking away when talking, the patient gets the impression that you attention is elsewhere. Speak clearly and distinctly in a normal tone of voice. This is especially necessary when you are talking with older people. Some of them, as part of the aging processes, may have a hearing loss. Talk with a patient, not just at him/her. Listen to the responses in an interested manner.

Verbal Communication

Slang or vulgar words are not appropriate or necessary. Also, do not use medical terms or abbreviations when talking to patients and their visitors. If you use medical language and the patient does not understand, you might give the patient the wrong idea about what is happening to him/her.

Keep your voice pleasant, not too loud and too high pitched. Speak clearly and slowly enough to be easily understood. Never whisper or mumble, even when you think the patient is asleep or cannot hear you. This is annoying to the patient.

Remember that, although some patients seem to be semicomatose, comatose, or unconscious, they may be fully aware of what is happening around them. Therefore, always speak and behave as if the patient can hear every word. (They may hear more than you think.)

Be sensitive to those times when the patient does not want to talk. Respect his or her moods. Saying nothing may have more meaning than any words or facial expressions. Sometimes a pat on the shoulder or holding a hand means more to a patient than anything you might say. Simply being near the stretcher or bed at the moment of trouble may be the most comforting message of all.

Barriers to Communication

FAILING TO LISTEN: Failing to listen suggests to the client, "I'm not interested" or "I'm bored" or "You are not important". It suggests that the nurse prefers to discuss topics that concern her/himself.

UNWARRANTED REASSURANCE: Statements such as "You'll feel better soon", "I'm sure everything will be all right", and "Don't worry" disregard the patient's feelings for the moment and are often said when there is no hope for improvement. The client who fears death needs to express concerns rather than having them dismissed with false reassurances.

JUDGMENTAL RESPONSES: Disapproving responses such as "That's good(bad)" or "You shouldn't do that" tell clients that they must measure up to the nurse's standards. Stereotyping responses such as "women are complainers" or "men don't cry" are judgmental and categorize clients.

DEFENSIVE RESPONSES: Clients may offer opinions or comments about their care directed toward the nurse, the nurse's colleagues, or the institution. Feeling threatened or attacked, the nurse may become defensive and prevent the client from expressing feelings. For example:

> Client: "The food is lousy here."
> Nurse: "It's a lot better here than in the county hospital."

This response protects the nurse from admitting weakness in health care services including personal weakness. They also prevent the client from expressing true concern.

CONDESCENSION: An attitude that conveys superiority over the other person. Calling a patient "honey" or "dear" casts the nurse in a role of superior mother and the patient in the role of the inferior child. Another condescending act is patting the elderly patient on the head.

LACK OF INTEREST: Conveys the message "I'm not concerned" or "What you say is not important". Forgetting part of a conversation or forgetting to respond or being in a hurry gives the appearance of not being interested.

Communication with Patients Who Do Not Speak or Understand English

Use flash cards, pictures, nonverbal communication, translator, or materials written in patient's language.

Communication with Blind Patients

Blind or visually handicapped must be shown and taught how to use signal. Describe how food is arranged on plate. Describe and show arrangement of furniture and articles in the room before any activity.

Deaf or Hearing Impaired Patient

When speaking, make sure you have the patient's attention. Face patient and speak clearly and slowly in normal tone. Many hearing impaired patients lip read. Use of pad and pencil is helpful.

Responses

ASSERTIVE: Behavior that is directed toward claiming one's rights without denying the rights of others.

AGGRESSIVE: Destructive behavior caused by frustration. The use of hostile behavior while ignoring the right of others.

PASSIVE-AGGRESSIVE: Term describing indirect expression, verbal or nonverbal, of angry feelings.

Communication with Visitors:

Certain actions are helpful in your contacts with visitors:

1. Listen to the family member. Whether it is a suggestion, a complaint, or "passing the time of day", listen to the person. Some suggestions by visitors can be very helpful. Some complaints may be valid, others not. When a complaint is presented, tell the person, "I will tell the head nurse about this," and then report it to the head nurse or team leader.
2. Do not get involved in the family's private affairs and feelings. Never take sides in family quarrels. Never give information or opinions to someone about other family members.
3. Be prepared to give information regarding the hospital to visitors. Tell them under what circumstances family members are allowed to eat in the employee cafeteria. Mention where the coffee shop is and what hours it is open. Tell them where a public telephone is. Direct them to other places in the institution, for example, the business office or the gift shop.

Three Main Rules Usually Apply to Visitors in Any Health Care Institutions:

1. Visitors are not allowed to take institutional property away with them.
2. Visitors who are not family members are not allowed to give nursing or medical care to a patient without a physician's order. Follow the policies of your employing health care institution.
3. Visitors cannot bring food or drink to the patient unless permission has been given by the head nurse or team leader.

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION II
Cultural Assessment Guide

Patient's Initials _____
Sex _____ Age _____
Race _____ Ethnic Group _____

Where were you born?

Where have you lived? ______________________ County? ______________

City? ______________________ How long? ______________________

Do you follow any customs, rituals or beliefs of your culture?

Do you have any food restrictions?

Is food prepared in a particular manner in your culture or your religion?

What would you normally eat while you have this condition?

Would you make any changes in your eating pattern or preparation of food?

What language or dialect do you speak more frequently?

When ? At home or work?

Which language do you use most of the time in thinking?

What does good health mean to you?

What do you believe causes illness?

Can illness be prevented? In what way?

What do you think caused your problem?

What treatment do you think you need now?

Do you have any healing practices that you follow from your culture?

What are the chief problems your illness has caused you?

Is it important that your family be present and participate in your care?

Is there a particular family memeber or members with whom you wish to consult when making decisions?

Do you seek cultural or religious healers to help you make decisions about health problems?

What do you believe happens when one dies?

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTRODUCTION TO NURSING - SECTION II
Ethical and Legal Issues

1. Identify four (4) functions of the Law of Nursing.

2. How does the Nurse Practice Act control nursing practice?

3. What is the purpose of the Nurse Practice Act?

4. What are Standards of Nursing Practice? When do they originate?

5. What is the function of the ANA Code of Ethics?

6. Define contract, liability, crime, tort.

7. Distinguish between intentional and unintentional torts and give examples of each.

8. Define malpractice/negligence.

9. Identify way in which nurses can protect themselves from malpractice lawsuits.

10. Identify potential malpractice situations involving medication errors.

11. Identify the three (3) major elements of informed consent.

12. Identify conditions that must be met for a will to be valid.

13. Identify Good Samaritan acts and their purpose.

14. Define ethics. What type of conflicts create ethical dilemmas? How can some ethical problems be prevented in the work place?

15. List your personal and professional values. Describe a nursing situation in which a professional responsibility may conflict with your personal values.

16. What are reportable abuses and communicable diseases according to state law?

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ITN/EthLegIs.F89

NURSING DIVISION
EVALUATION INFORMATION

Attached is the evaluation tool that is used by the faculty to evaluate student achievement of clinical objectives.

You are expected to use this as a guideline in monitoring your progress in achieving the clinical objectives.

Please complete this and bring it with you to your clinical conference.

A student who is not achieving all of the clinical objectives will be expected to meet with his/her clinical instructor to discuss the lack of progress. A signed copy of the remediation plan is issued to the student.

DIRECTIONS FOR DETERMINING CLINICAL GRADES

1. Mark level of student performance for each objective, writing in "not observed" when applicable.
2. Add the checks in each column and multiply this sum by the numerical weight (0 = 4, S = 3, M = 2, U = 1)
3. Divide the total obtained in step 2 by the number of objectives assessed, (ie do not count objectives marked "not observed) to determine score
4. Convert score to percentage grade based on scale below keeping in mind that all critical indicators (marked by an asterisk) must be met at the satisfactory level for students to receive a passing grade in clinical
5. Calculate course grade by multiplying theory grade by .6 and clinical grade by .4 and adding the two figures.

GRADING SCALE

PERCENTAGE	POINTS	LETTER GRADE
100	4.00	
99	3.94	
98	3.88	
97	3.82	
96	3.76	
95	3.70	
94	3.64	
93	3.58	
92.5	3.55	A
92	3.52	
91	3.46	
90.5	3.43	A-
90	3.40	
89	3.34	
88.5	3.31	B+
88	3.28	
87	3.22	
86	3.16	
85	3.10	
84.5	3.07	B
84	3.04	
83	2.98	
82.5	2.95	B-
82	2.92	
81	2.86	
80.5	2.83	C+
80	2.80	
79	2.74	
78	2.68	
77	2.62	
76.5	2.56	C
76	2.53	
75	2.50	C-
74 and below	2.49 and below	F

*Critical Indicators Must Receive a Satisfactory Score

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN

CLINICAL

COURSE: INTRODUCTION TO NURSING

DATE: ____________________

Outstanding. Consistently superior in clinical performance, skill, synthesis of learning and application of nursing principles. Functions above expectations of student at this level.

1. Consistently functions safely and effectively with minimal guidance.
2. Demonstrates superior ability to analyze and synthesize information.
3. Demonstrates sound clinical judgement.
4. Seeks out and assumes responsibility beyond that required.

Satisfactory. Safe clinical performance demonstrates expected skills, synthesis of learning and application of nursing principles at expected level.

1. Consistently functions safely and effectively with occasional guidance.
2. Demonstrates ability to analyze and synthesize information with occasional guidance.
3. Makes appropriate clinical judgements with guidance.
4. Recognizes own limitations and seeks appropriate assistance.

Scale Points	O	S	M	U	Supportive Statements
Member of Discipline					
1.0 Demonstrate awareness of the nurse's role as member of discipline					
1.1 Utilizes instructor as first link in chain of command					
1.2 Interprets school/agency policy					
1.3 Protects client confidentiality					
1.4 Accepts responsibility for own action					
1.5 Seeks further information when needed					
Subscore					
Provider of Care					
2.0 Uses assessment and implementation skills to meet clients' needs for hygiene skin integrity, mobility, protection, fluid imbalance, elimination and nutrition					
2.1 Obtains data from Kardex, chart and client					
2.2 Follows pre-established plans of care					
2.3 Demonstrates basic nursing skills safely and effectively					
2.3a Personal Care					
2.3b Elimination					
2.3c Mobility					
2.4 Utilizes therapeutic communication					
2.5 Observes and reports effects of nursing care					
2.6 Documents nursing care on graphic and flow records					
Subscore					

EVALUATION

☐ INSTRUCTOR ☐ STUDENT

Minimal. Clinical performance: is safe, background knowledge is deficient. Inconsistent safe clinical performance; demonstrates expected skills, synthesis of learning, and application of nursing principles at expected level with direct supervision.

1. Functions safely and effectively with frequent supervision.
2. Analyzes and synthesizes information with much guidance.
3. Accepts own limitations with guidance and uses resources as directed.
4. Accepts clinical judgements of staff and instructor.

Unsatisfactory. Clinical performance inadequate; indicates lack of skill, unsafe nursing practice, inadequate depth of knowledge, or application of nursing principles. Functions below expectations of student at this level.

1. Unable to function safely and effectively without constant supervision.
2. Unable to analyze and synthesize information with guidance.
3. Unable to make appropriate clinical judgements.
4. Does not accept responsibility for own actions.

Scale Points	O	S	M	U	Supportive Statements
Manager of Care					
3.0 Manage selected aspects of care for individual clients					
3.1 Provides care efficiently					
3.2 Identifies supplies available on nursing unit					
3.3 Organizes own time to provide care for one client					
3.4 Recognizes priorities for client care					
Subscore					
Investigator					
4.0 Uses basic text for information relevant to client care					
Subscore					
TOTAL SCORE					

INSTRUCTOR'S SIGNATURE

STUDENT'S SIGNATURE

DATE

DATE

GRADE

REV10-89/ITN/ClinEval.F89

EXHIBIT I

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

COURSE SYLLABUS

COURSE TITLE: Nutrition for Nursing Practice

COURSE NUMBER: 510-115 CREDITS: 2

PREREQUISITES: General Chemistry
Introduction to Nursing

LEAD INSTRUCTOR: Roz Anderson

RESOURCES:

Cataldo, Nyenhuis, and Whitney, Nutrition and Diet Therapy, 1989, West Publishing Company, St. Paul, MN.

Metheny, Fluid and Electrolyte Balance: Nursing Considerations, 1987, J. B. Lippincott Company, Philadelphia, PA.

COURSE DESCRIPTION:

Study of basic principles of nutrition and hydration which underlie nursing assessment, diagnosis, and intervention in relation to the health patterns of the developing person. The course focuses particularly on the nutrition/metabolic pattern. Includes overview of nutrients and normal functions of nutrients and fluids in the body with emphasis on the changing needs of individuals as they progress through the life span. Also addressed are modified diets and nutritional therapies as methods of promoting nutritional intake for persons with special needs.

COURSE OBJECTIVES:

The course provides learning experiences which will enable the student to:

Knowledge Base

IVa. identify sources, characteristics, and functions of all major nutrient groups.

IVb. describe normal fluid balance in the body.

IVc. assess the nutrition/metabolic pattern of clients of various ages.

IVd. describe nutritional aspects of intravenous water and mineral solutions, total parenteral nutrition, and tube feedings.

IVe. discuss types, purposes, and general content of common therapeutic diets.

IVf. identify ways in which foods can pose chemical, physical, biological and psychological hazards to individuals.

Critical Thinking

IVg. exercise critical and creative thinking skills in the development of a nutrition project. (See attached project guidelines.)

Humane Caring

IVh. identify aspects of nutrition science that are relevant to the provision of humane caring, specifically:

1. identify the role of food in human need gratification in a variety of situations.
2. identify cultural and age related issues and problems relevant to nutritional care.

UNITS OF INSTRUCTION:

1. Characteristics of Basic Nutrients
2. Assessment and Promotion of Normal Nutrition Across the Lifespan
3. Nutritional Therapy

METHODS OF INSTRUCTION:

Lecture, discussion, take-home examinations, nutrition project

METHODS OF EVALUATION:

Students will be evaluated on the basis of three take-home examinations, two in-class examinations, and one individual or shared nutrition project (see guidelines for project).

GRADING:

Students must achieve a 78% average to pass the course. The course grade will be determined as follows:

three take-home exams - 45%
nutrition project - 15%
midterm exam - 20%
final exam - 20%

Criteria for grading of the nutrition projects as well as guidelines for development of the projects will be attached to the syllabus.

POLICIES AND PROCEDURES:

Attendance will be taken for all class periods. Students who are absent for in-class examinations due to illness or other serious difficulty will be given the option of making up the examination in essay form. Take-home examinations which are not returned by the designated due dates will have two (2) points deducted per each school day late.

RA/6-89/bh
Nutri/CSyll.W90

UNIT I: Characteristics of Basic Nutrients

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
Discuss variables in food selections.	1. Course overview 2. Nutrition overview; food groups, standards, nurse's role	C: 2-19
Determine standards of nutritional adequacy.		
Discuss role of nutrition in nursing.		
Describe sources, characteristics, and functions of CHO, protein vitamins, minerals, and water.	3,4. CHO, fats, proteins	C: 22-63
Describe digestion, absorption, transport, and use of major nutrients.	5,6. Digestion, absorption, metabolism (Take-home Exam 1)	C: 66-96
Describe characteristics of fat soluble and water soluble vitamins.	7,8. Vitamins	C: 100-130
Describe general effects of deficiencies of vitamins A, D, E, K, C, B_{12} and folate specifically, and the other B vitamins in general.		
Describe general functions of minerals in the body, distinguishing between major minerals and trace elements.	9,10. Water and minerals	C: 134-158
Describe mechanisms of water balance.	11,12. Assessment of water and mineral balance	M: 3-35
Describe techniques for assessment of water and mineral balance.	(Take-home exam 2)	

UNIT II: Assessment and Promotion of Normal Nutrition Across the Lifespan

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
Describe the relationships among nutrition, exercise, and optimal health.	13. Nutrition and fitness	C: 162-181
Describe nutrient needs and risks of persons during pregnancy, lactation and infancy.	14,15. Mother and infant nutrition	C: 184-209
Describe strategies to meet nutrient needs in pregnancy, lactation and infancy.		
Describe nutrient needs and special problems of children and teenagers.	16. Child and teen nutrition	C: 212-231
Discuss strategies to meet nutritional needs of children and teenagers.		
Discuss effects of aging on nutrition.	17. Adult nutrition effects of aging	C: 234-251
Describe strategies to meet nutritional needs of adults and the elderly.	18. Midterm Exam.	
Describe major cultural groups in the United States.	19,20 Promoting nutrition in different sociocultural situations	Suitor and Hunter pp. 53-64, on reserve
Describe the roles of food in various cultures.		
Describe cultural practices designed to promote adequate nutritional intake.		
Describe techniques of nutritional assessment: diet history, anthropometrics, physical exam, laboratory tests.	21,22 Assessment of nutritional status, nutrition care planning	C: 254-279

Describe basic nutrition care planning strategies.

UNIT III: Nutritional Therapy

UNIT OBJECTIVES	CONTENT	LEARNING ACTIVITIES
Describe food services offered in health care facilities.	23. Nutrition and food in the institutional setting	C: 282-303
Describe purpose, characteristics, and implications (including risks) of use of: -water and electrolyte solutions -parenteral nutrition solutions -tube feeding formulas	24. Water and electrolyte solutions 25. Parenteral nutrition 26. Enteral nutrition (Take-home Exam 3)	M: 144-170 C: 306-338
Describe purposes and components of specific modified diets.	27,28. Diets modified in texture, amount, calories	C: 340-419
Describe strategies to promote adherence to specific modified diets.	29,30. Diets modified in CHO (Nutrition Project due)	C: 422-447
	31,32. Diets modified in fat	C: 450-489
	33,34. Diets modified in protein, minerals, water	C: 492-513
	35. Final Exam	
	36. Course project display, course evaluation	

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

NUTRITION FOR NURSING PRACTICE
Nutrition Project Guidelines

The nutrition project is designed to allow you to study a topic in nutrition that is of special interest to you and to create a product reflecting the new knowledge and/or skill that you attain. We would like the nature of your project to be your own idea. In order to provide some consistency in terms of effort invested and the scope of the project as well as to provide a basis for grading of the project, the following guidelines will apply.

1. You may work individually or in groups of two or three students.
2. We will expect approximately eight hours per student to be devoted to the project and the grade assigned will be based on that expectation.
3. The project must result in an attractive, visually stimulating, tangible product suitable for display and/or use by nursing students.
4. The project must reflect accurate understanding of a nutritionally relevant topic which has been attained through critical evaluation and integration of information from multiple sources.
5. The project must include a bibliography reflecting use of current nutrition texts, journals, and/or resource persons.
6. The project grade will comprise 15% of your course grade. Students working in groups will each receive the single grade assigned to their project.

Examples of nutrition projects include:

1. development of a picture book suitable for use by a 4-6-year-old, newly diagnosed, diabetic child.
2. translation of a "family favorites" recipe collection into recipes adapted for a diabetic family member (or cholesterol restricted, etc.).
3. translation of the basic four food groups into foods used by three different ethnic groups--including pictures, recipes, and/or samples of food items. Organize the material as a working tool for nurses responsible for diet teaching.

The above are only examples. Be creative and do your "own" thing! Feel free to contact course instructors if you have questions.

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

510-115 NUTRITION FOR NURSING PRACTICE
Nutrition Project Evaluation Criteria

The nutrition project will be evaluated according to the criteria listed below. Each area will be given a separate letter grade. The three letter grades will then be averaged to give you your total nutrition project grade which will comprise 15% of your course grade.

		GRADE
1.	The project demonstrates an understanding of current relevant and accurate nutritional information.	_____
2.	The project is creative and visually stimulating.	_____
3.	The nutrition project is supported by a variety of resources, i.e., nutrition texts, professional journals, media, resource persons. A bibliography is included and written according to APA format.	_____

TOTAL PROJECT GRADE _____

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

NUTRITION FOR NURSING PRACTICE
Take Home Exam 1
Directions and Grading Form and Short Answer Questions

DUE: FEBRUARY 5, 1990

		Points Possible	Points Achieved
A.	Nutrient Intake Analysis: Complete forms 1-5 on pages 14-17 in CNW.		
1.	Three days of food intake recorded with approximate measure or weight.	5	
2.	All nutrient content recorded for each food item computed to values given on Table C-1.	10	
3.	Nutrient intakes averaged correctly and compared to standards. (Forms 2 & 3).	5	
4.	Food selection scorecard completed accurately (Form 4).	2	
5.	Percentage of calories from protein, fat, CHO correctly computed (Form 5).	1	
B.	Short Answer: see questions on following pages.	1	
1.	RDAs	2	
2.	CHO	2	
3.	FAT	4	
4.	PRO	2	
5.	D/A/M	5	
	Total Points:		
	Percent Achieved:		
	Letter Grade:		

Nutrition for Nursing Practice
Short Answer Questions

1. Who establishes the RDAs, what are they, and what is their purpose?

2. Discuss four functions of carbohydrates.

3. Explain the difference between saturated and unsaturated fat and how each affects nutrition and health.

4. Why are proteins considered to be wasteful source of energy?

5. Trace the path of glucose in a Hershey Bar from the wrapper, through your body, to its conversion to H_2O, CO_2 and energy. (Hint: figures 5-1 and 6-1 are helpful in answer this.)

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CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

NUTRITION FOR NURSING PRACTICE
Take Home Exam 2
Directions and Grading Form

DUE: February 26, 1990

Please read and complete the following self-studies in your nutrition book. Follow the directions carefully and answer all the questions in each study. You may photocopy the self-studies and answer the questions in the margin. Please be complete and accurate in your work. Refer to your work on the first take-home-exam as needed to answer the questions.

	Points Possible	Points Achieved
1. Carbohydrate Intake Self-study p. 28-29	5	
2. Fat Intake Self-study p. 42-43	5	
3. Protein Intake Self-study p. 59-60	5	
4. Energy Expenditure Self-study p. 92-93	10	
5. Water and Mineral Intake Self-study p. 155-156	10	

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Nutri/THExam2.W90p

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

NUTRITION FOR NURSING PRACTICE
Lesson Plan: Assessment of Fluid and Mineral Status

1st Hour: Lecture and discussion regarding history, clinical signs and symptoms and laboratory norms related to fluid and mineral balance.

2nd Hour: "Fluid and Mineral Trivial Pursuit"

Materials: 4 identical game sets including game boards, dice, question/answer cards on the following topics:
- clinical findings
- urine findings
- blood findings

Process: Divide students into four groups and then each group divides into two teams. Play "Trivial Pursuit" game according to rules ready by the instructor. Students take turns attempting to answer each question and after each question is answered, the correct answer is read from the back of the card. Students are encouraged to discuss rationales for the correct answers.

Evaluation of First Use: Students appeared to enjoy the game and to find the information on the cards useful. Much discussion occurred during the game and students seemed intent on integrating the facts and concepts into their knowledge bases. Several students stopped by later to borrow the card decks for their own use later.

RA/2-90/bh
Nutri/LessonPl.W90

EXHIBIT J

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing-Technical Program

Course Syllabus

COURSE: 510-122 Pathophysiology I CREDITS: 2

PREREQUISITES: 806-125 General Chemistry
806-140 Anatomy and Physiology

PREREQUISITE OR CONCURRENT: 806-132 Microbiology

LEAD INSTRUCTOR:

RESOURCES:

Textbooks: Porth, C. M., Pathophysiology: Concepts of Altered Health States, 2nd ed., Lippincott, 1986.

References: Metheney, N. M., Fluid and Electrolyte Balance: Nursing Considerations, Lippincott, 1987.

Tortora, G. J. and Anagnostakos, N. P., Principles of Anatomy and Physiology, 5th ed., Harper and Row, 1987.

COURSE DESCRIPTION:

This course is designed to increase the student's knowledge of physiologic and pathologic mechanisms which influence a person's dynamic health status. Disease agents and situations as well as the body's adaptive responses to these stressors are examined in order to increase understanding of the complex concept of homeostasis as it contributes to positive health. This course is part of a two course sequence and specific areas of study in this course include: cellular functions and growth, body defense mechanisms, oxygenation, and fluid, electrolyte, and body waste balance. This course builds upon concepts previously learned in Chemistry, Anatomy and Physiology, and Microbiology.

COURSE OBJECTIVES:

This course provides learning experiences which will enable the student to:

Knowledge Base

1. Understand general principles underlying physiologic stress and adaptation in man.
2. Describe the body's specific and general mechanisms of defense against disease and injury.
3. Describe common patterns of impairment of oxygenation in man.
4. Describe factors which regulate and factors which impair fluid and solute balance in the body.

Humane Caring/Critical Thinking

1. Recognize key concepts in pathophysiology that impact a patient's response to health and illness.

UNITS OF INSTRUCTION:

1. Alterations in cell function and growth
2. Alterations in body defenses
3. Alterations in oxygenation
4. Alterations in fluid and solute balance

METHODS OF INSTRUCTION: Lecture and discussion.

METHODS OF EVALUATION AND GRADING:

Four objective in-class unit examinations and one take-home examination will determine the course grade as follows:

Exam 1	15%
Exam 2	20%
Exam 3, Take-home	15%
Exam 4	25%
Exam 5	25%

The student must achieve an average of 78% to pass the course.

POLICIES AND PROCEDURES:

Students are strongly encouraged to attend all class sessions. Attendance will be taken at all class sessions as specified by Chippewa Valley Technical College policy.

Examinations may be missed only due to illness or other serious difficulty. Examinations which are missed may be made up within one week of the original test date by completion of an alternate essay test form. Two percentage points will be deducted from the take-home examination grade for each school day late.

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APPROXIMATE SCHEDULE OF LEARNING ACTIVITIES

1. Course introduction
2. Cell adaptation and injury
3. Genetic control of cell function and inheritance
4. Genetic and chromosomal disorders
5. Neoplasia
6. Neoplasia
7. EXAM #1
8. Stress and adaptation
9. Inflammation and repair
10. Altered immune responses
11. Altered immune responses
12. WBC and lymph disorders
13. Hemostasis and hemolysis
14. EXAM #2
15. RBC and oxygen transport
16. Blood flow alterations
17. Hyper- and hypotension
18. Hyper- and hypotension
19. Altered cardiac function
20. Altered cardiac function
21. Altered cardiac function........EXAM #3 (TAKE-HOME) DUE 1 WEEK
22. Heart failure
23. Circulatory shock
24. Altered respiratory function
25. Altered respiratory function
26. Altered ventilation
27. Respiratory failure
28 EXAM #4
29. Altered fluids and electrolytes
30. Altered fluid distribution
31. Acid-base imbalance
32. Acid-base imbalance
33. Altered renal function
34. Renal failure
35. Altered urine elimination
36. UNIT EXAM #5

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Patho/P1CSyll.W90

Pathophysiology I
Course Syllabus/Outline

UNIT I: Alterations in Cell Function and Growth

TOPIC	OBJECTIVES	READING (* = optional)
Course Introduction	Understand goals and methods of course.	Course Syllabus
	Identify strategies for learning complex science concepts.	
Cell Adaptation and Injury	Explain how the body is injured at the cellular level by various agents.	P: Ch 1* P: Ch 2
	Describe cell's mechanisms for adaptation to protect and repair self.	
Genetic and Chromosomal Dysfunction	Describe causes of gene and chromosome injury.	P: Ch 3, 4
	Explain common modes of inheritance of genetic and chromosomal disorders.	
	Describe features of selected common genetic and chromosomal disorders.	
Neoplasia	Describe differences between normal tissues and neoplasms.	P: Ch 5
	Describe cancer classification systems.	
	Describe theories of carcinogenesis.	
	Describe effects of cancer on the body.	

UNIT II: Alterations in Body Defenses

Stress and Adaptation	Describe major features of the stress response.	P: Ch 6
	Explain the effects of hormones released during the stress response.	

Pathophysiology I
Course Syllabus/Outline

TOPIC	OBJECTIVES	READING (* = optional)
Inflammation and Repair	Explain events comprising the acute inflammatory response at the cellular level.	P: Ch 7* P: Ch 8
	Contrast acute and chronic inflammation.	
	Describe the positive and negative effects of inflammation on the body.	
	Relate the steps of wound healing to care of clients with wounds.	
Immune System Dysfunction	Describe the major components of the immune system.	P: Ch 9, 10
	Explain active and passive immunity.	
	Describe general causes of immune deficiency.	
	Explain cause and effects of AIDS.	
	Explain four classes of hypersensitivity reactions.	
	Explain the basis of transplant rejection and autoimmune disorder.	
WBC and Lymphatic Disorders	Describe characteristics of leukemias, lymphomas, and multiple myeloma.	P: Ch 11
Hemostasis and Hemolysis	Describe mechanisms of hemostasis including but not limited to coagulation.	P: Ch 12
	Describe causes of hypercoagulability and impaired hemostasis.	
	Explain systemic results of hypercoagulability and impaired hemostasis.	

TOPIC	OBJECTIVES	READING (* = optional)
	Describe rationale for use of heparin, coumadin and fibrinolytic agents.	

UNIT III: Alterations in Oxygenation

RBC Dysfunction	Describe causes and characteristics of various types of anemias.	P: Ch 13
	Describe causes and effects of polycythemia.	
	Discuss mechanisms and effects of blood transfusion reactions.	
Blood Flow Alterations	Describe causes and effects of obstructed blood flow in arteries and veins.	P: Ch 14* P: Ch 15
	Describe factors resulting in development and healing of pressure sores.	
Hypo and Hypertension	Explain mechanisms that control blood pressure.	P: Ch 16* P: 227-233, Ch 17
	Describe causes and effects of primary and secondary hypertension.	
	Explain malignant hypertension.	
	Discuss causes and effects of orthostatic hypotension.	
Alterations in Cardiac Function	Describe causes and characteristics of major categories of alterations in cardiac function: -inflammatory disorders of the pericardium, endocardium and myocardium -coronary heart disease -arrhythmias -valvular heart disease -cardiomyopathy -congenital syndromes	P: Ch 18*

TOPIC	OBJECTIVES	READING (* = optional)
Heart Failure	Explain mechanisms and symptoms of left and right heart failure.	P: Ch 20
Circulatory Shock	Define shock. Describe characteristics of four major types of shock. Explain complications of systemic shock.	P: Ch 21
Alterations in Respiratory Function	Explain normal altered physiology of gas exchange in the lungs including: -ventilation/perfusion relationships -alveolor gas exchange -oxyhemoglobin dissociation -cyanosis, hypoxia, dyspnea. Explain causes and effects of common categories of lung disorders: -infectious disorders -pleural disorders -obstructive disorders -interstitial disorders -vascular disorders -cancer.	P: Ch 22* P: 346-358, Ch 23
Altered Ventilation and Respiratory Failure	Explain mechanisms of hypo- and hyperventilation. Describe signs and symptoms of respiratory failure.	P: Ch 24

UNIT IV: Alterations in Fluid and Solute Balance

Altered Fluid and Electrolyte Balance	Explain regulation of body fluid balance by thirst mechanism, renal mechanism and ADH. Describe causes and results of ECF excess and deficit.	P: Ch 25 Metheney: TBA

TOPIC	OBJECTIVES	READING (* = optional)
	Describe causes and results of excess or deficit of Na+, K+, and Ca++.	
Altered Distribution of Fluids	Explain mechanisms of edema development.	P: Ch 26 Metheney: TBA
	Describe characteristics of edema.	
Altered Acid-Base	Explain buffer systems in the body.	P: Ch 27 LLS: Respiratory Care, pp. 27-34
	Explain laboratory measures of pH balance.	
	Describe causes and symptoms of acidosis and alkalosis.	
Altered Renal Function	Describe causes and results of major categories of renal dysfunction: -congenital -infectious -obstructive -neoplastic -other.	P: Ch 28* P: Ch 29
Renal Failure	Describe causes and results of acute and chronic renal failure.	P: Ch 30
Altered Urine Elimination	Describe causes and results of urinary incontinence and retention.	P: Ch 31

EXHIBIT K

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associated Degree Nursing-Technical Program

Course Syllabus

COURSE: 510-130 Pharmacology CREDITS: 2 (36 hours)

PREREQUISITES: General Chemistry
Introduction to Nursing

LEAD INSTRUCTOR: Kay Froehner

RESOURCES:

Textbook: Shlafer, M., and Marieb, E., The Nurse, Pharmacology and Drug Therapy, 1989, Addison-Wesley Publishing Company, Redwood CA

COURSE DESCRIPTION:

This course will study the basic pharmodynamics and pharmotherapeutics of the major drug classifications. The nursing process will be utilized when examining the nurse's role and responsibilities of drug therapy across the life span. The student will explore the psychosocial/cultural and legal/ethical issues related to drug therapy. Specific concepts will include calculating medication dosages.

COURSE OBJECTIVES:

This course provides learning experiences which will enable the student to:

Knowledge Base

1. Utilize the nursing process in the assessment, nursing diagnosis, implementation and evaluation of drug therapy across the life span.
2. Examine the psychosocial/cultural aspects of drug therapy.
3. Describe the nursing roles as they relate to drug therapy.
4. Examine the ethical/legal considerations of drug therapy.
5. Describe the pharmodynamics and pharmokinetics of the major drug classifications.

Humane Caring

6. Demonstrate a caring approach by analyzing the impact of the media on self-medication practices of the consumer.

Critical Thinking

7. Apply critical thinking skills in the development of the pharmacology projects.

UNITS OF INSTRUCTION:

1. Nursing Roles in Drug Therapy
2. Pharmokinetics
3. Legal/Ethical Considerations in Drug Therapy
4. Psychosocial/Cultural Aspects of Drug Therapy
5. Drugs that Affect Autonomic and Somatic Nervous Systems
6. Drugs that Affect Central Nervous System
7. Drugs that Affect the Cardiovascular and Renal System
8. Drugs that Affect the Respiratory System
9. Drugs that Affect Gastrointestinal Tract
10. Hormones, Hormone Antagonists and Other Drugs that Affect Endocrine System
11. Drugs that Affect Immune System
12. Antimicrobials
13. Chemotherapeutics/Antineoplastics

METHODS OF INSTRUCTION:

Large group lectures
Small group discussions
Audiovisual materials
Case studies
Take home exam
Pharmacology project

METHODS OF EVALUATION:

Students will be evaluated on one take-home exam, four in-class exams, and two pharmacology projects.

GRADING: The course grade will be determined as follows:

Four in-class exams and one take-home exam = 90%
Two pharmacology projects = 10%

Passing grade will be 78%.

POLICIES AND PROCEDURES:

Role will be taken each class period. Absences are recorded on the student's record and reported to Student Services where they are recorded on the student's record. Students are strongly encouraged to attend all class sessions. Take-home examinations which are not returned by the designated due date will have two (2) points deducted per each school day.

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Pharm/Syllabus.W90

UNIT 1: Nursing Roles in Drug Therapy

Objectives	Outline	Learning Activity
Identify the general classification of drugs.	Classification of Drugs: a) name b) function c) legal d) over-the-counter e) orphan	Shlafler Chapters 1 and 2
Utilize the nursing process in describing nursing roles.	Application of Nursing Process to Drug Therapy: a) assessment b) nursing diagnosis c) implementation d) evaluation	
Identify the common systems of measurement, medication terminology and abbreviations used in drug administration.	Systems of Measurement: a) calculating dosages b) IV calculation c) converting units of weight and measurement	
Accurately calculate medication dosages.	The Medication Order: a) four parts of medication order b) contraindicated orders	
Identify the four essential components of a medication order.	Drug Preparation Forms	
Describe the seven routes of medication administration.	Routes of Administration: a) oral b) sublingual c) topical d) instillation e) inhalation f) buccal g) parental	
Describe five guidelines for drug administration.	Guidelines for Drug Administration: a) the "five rights" b) documenting drug administration	
Describe common procedures for recording and reporting medication errors.	c) medication errors and incident reports d) causes of medication errors	

UNIT 2: PHARMOKINECTICS

Objectives	Outline	Learning Activity
Define pharmacokinetics, pharmacodynamics, and pharmacotherapeutics.	Selected definitions: pharmacokinecs, pharmacodynamics, pharmacotherapeutics	Shlafer, Chapter 4, pp. 49-65
Identify the four processes which affect pharmacokinetics.	Pharmacokinetics: absorption, distribution, metabolism, excretion	Shlafer, Chapter 5, pp. 66-75
Identify the time response affects of drug actions.	Time-response affects: single-dose administration, repeated-dose administration	Shalfer, Chapter 6, pp. 76-89
Identify the variables which affect pharmacodynamics.	Pharmacodynamics: drug receptors, drug agonists, drug antagonists, dose-response relationship	Shalfer, Chapter 7, pp. 90-101
Describe physiologic factors which underlie adverse drug effects.	Physiologic factors: age, gender, denetics, disease, nutrition, others	Shlafer, Chapter 8, pp. 109-119
Identify adverse effects from single-dose administration.	Adverse-drug effects: patient-related factors, iatrogenic factors, pharmacologic factors	
Identify five adverse affects from multiple-drug administration.	Single-dose adverse effects: allergy, idiosyneratic reactions, cumulative effects, toxicity, tolerance, dependence, tissue damage, carcinogenesis, mutagenesis, teratogenesis	
Discuss the nursing process in relationship to adverse drug effects.	Multiple-drug adverse effects: addition, summation, synergy, potentiation, antagonism	
	The nursing process: nursing diagnosis, nursing implications	

Pharmacology
Course Syllabus/Outline

UNIT 3: Legal/Ethical

Objectives	Outline	Learning Activity
Discuss the significance of selected federal and state laws to the development, manufacture and administration of drugs.	Federal and State Drugs: a) Pure Food & Drug Act of 1906 b) 1951 Durham-Humphrey Amendments c) Harrison Narcotic Acts d) Comprehensive Drug Abuse Prevention and Control Act	Chapter 3
Discuss how the state practice acts relate to medication administration.	e) State Practice Acts: 1) nurse 2) physician 3) pharmacist	
Compare and contrast Schedule I through Schedule V drugs for: potential for abuse, accepted medical uses, and potential for dependence.	Schedule of Controlled Substances:	
Define malpractice and negligence.	Malpraction definition Negligence definition	
Discuss the expanded role of the nurse as it relates to medication administration.	Role of the nurse	

UNIT 4: PSYCHOSOCIAL/CULTURAL ASPECTS OF DRUG THERAPY

Objectives	Outline	Learning Activity
Define ethnicity, ethnomedicine, ethnopharmacology, and homeopathy.	Selected definitions: ethnicity, ethnomedicine ethnopharmacology, homeopathy	Spencer, 3rd edition Chapter 12, pp 132-149 Mosby, pp. 115-122
Identify three ethnopharmacological treatments for selected ailments.	Ethnopharmacological treatments: herbs, leaves, spices Cultural background and health beliefs	
Discuss the influence of culture and psychological beliefs on drug therapy.	Symbolic meaning of medications: help, danger, secondary gains	
Identify the symbolic meaning of drugs to clients.	Compliance: illness, symptoms, convenience, others	
Differentiate between the advantages and disadvantages of pharmacological homeopathy.	Pharmacological homeopathy: advantages: patient control disadvantages: inadequacy	
Identify cultural influences on self-medication and behaviors.	Cultural influences on self-medicating behaviors: study results, implications for nursing interventions.	

UNIT 5: DRUGS THAT AFFECT CENTRAL NERVOUS SYSTEM

Objectives	Outline	Learning Activity
Identify two classifications of anesthetic agents: 1) local 2) general (inhalation) Identify the pharmacologic effects and mechanisms of selected anesthetic drugs. Identify the main clinical indications and administration of selected anesthetic drugs. Identify six adverse reactions, contraindications, and drug interactions of selected anesthetic drugs. Identify clients at risk of developing toxicity to anesthetic drugs.	Classification: local anesthetic agent Action: suppress the activity of sensory nerves and all excitable tissue Indications & Administration: regional analgesics, anesthesia, topical, SQ, IV Adverse Reactions: restlessness, anxiety, wheezing, dyspnea, hypotension paresthesia Contraindications: seizures, hyoptension Drug Interactions: antiarrhythmic--increased risk of bradycardia, Tagamet--side effects Nursing Implications: Assessment: adverse reactions Nursing Dx: Interventions: keep emergency drugs and support at hand Evaluation: safe expected drug response Teaching/Learning: pre-op teaching Implications Across the Life Span: used during labor and delivery, reduced dosages for children, elderly--greater risk of hypotension Toxicity: affects CNS and CVS. PROTOTYPE: Lidocaine.	Pages 300-310 314-322
List the signs and symptoms of toxicity to Hallothane. Identify appropriate nursing assessments, diagnosis, interventions, and evaluation of patients receiving anesthetics. Develop a teaching/learning plan for patients receiving anesthetics. Examine the implications of anesthetic therapy across the life span.	Classification: general anesthetic (inhalation) Action: depression synaptic transmission in CNS Indications & Administration: general anesthesia Adverse Reactions: decreases circulatory function, decreased cardiac output, cardiac arrhythmias, depressed ventilation Contraindications: increased intracranial pressure Drug Interactions: sympathonimetic aminesarrhythmias Nursing Implications: Assessment: side effects, Hx of drug abuse Nursing Dx: Interventions: maintain body temperature Evaluation: safe response of anesthetic agent Teaching/Learning: general pre-op teaching Implications Across Life Span: PROTOTYPE: Halothane.	

Objectives	Outline	Learning Activity
Identify the pharmacologic effects and mechanisms of selected narcotic analgesic drugs. Identify the clinical indications and administration of selected narcotic analgesic drugs. Identify adverse reactions, contraindications and drug interactions of selected narcotic analgesic drugs. List the signs and symptoms of overdose to narcotic analgesics. Identify appropriate nursing assessments, diagnosis, interventions, and evlauation of patients receiving narcotic analgesics. Develop a teaching/learning plan for patients receiving narcotic analgesics. Examine the implications of narcotic analgesics therapy across the life span. Identify one narcotic antagonist for managing narcotic overdose.	Classification: narcotic analgesic Action: depresses the CNS Indications & Administration: relief of moderate to severe pain, PO, IM, IV Adverse Reactions: sedation, decreased respiratory rate, hypotension, nausea, vomiting Contraindications: impaired neurologic status, constipation, hypotension Drug Interactions: amphetamines antagonize, Tagamet--increase sedation Nursing Implications: Assessment: side effects, pain relief, V.S. Nursing Diagnosis: alteration in comfort Interventions: give at regular intervals, give 30-60 minutes before painful procedure Evaluation: pain relief Teaching/Learning: risk of developing tolerance and dependence Implications Across Life Span: avoid in pregnancy, elderly--increased sedation. PROTOTYPE: morphine sulfate. Classification: narcotic antagonist Action: block opiate receptors, reverse narcotic effects Indications and Administration: reverse respiratory depression, physical dependence, expect withdrawal syndrome. PROTOTYPE: Narcan.	Pages 332-346 351-353
Identify the pharmacologic effects and mechanisms of central nervous system stimulants.	Classification: Central Nervous System Stimulants Action: sympathomimetic effects, release norepinephrine from adrenergic nerve endings Indications and Administration: obesity,	Pages 510-528

Objectives	Outline	Learning Activity
Identify three main clinical indications and administration of selec- CNS stimulants. Identify five adverse reactions, contraindications and drug interactions of selected CNS stimulant drugs. Identify clients at risk of developing toxicity to CNS stimulants. List the signs and symptoms of toxicity to CNS stimulants. Identify appropriate nursing assessments, diagnosis, interventions, and evaluation of patients receiving CNS stimulants. Develop a teaching/learning plan for patients receiving CNS stimulants. Discuss the implications of CNS stimulant therapy across the life span.	attention deficit disorder, narcolepsy Adverse Reactions: restlessness, dizziness, agitation, insomnia, palpitations, hypertension Contraindications: history of drug abuse Drug Interactions: CNS depressants antagonize stimulant effects, alkalinizing agents increase stimulant effects Nursing Implications: Assessment: drug history nonprescription medicines, vital signs Nursing Dx: Interventions: give no later than 6 hours before noc, monitor BP, heart rate Evaluation: Teaching/Learning: risk of dependence, avoid caffeine Toxicity: overdose common Implications Across the Life Span: avoid in pregnancy, elderly more sensitive to all effects of CNS stimulants. PROTOTYPE: Dextroamphetamine	

Objectives	Outline	Learning Activity
Identify two classifications of CNS sedatives: 1) barbiturates 2) anxiolytics. Identify the pharmacologic effects and mechanisms of selected CNS sedatives. Identify the main clinical indications and administration of selected CNS sedatives. Identify six adverse reactions, contraindications and drug interactions of selected sedative drugs. Identify clients at risk of developing toxicity to barbiturates. List the signs and symptoms of toxicity to barbiturates.	Classification: Barbiturate Action: CNS depression Indications & Administration: sedation, hypnosis, management seizure disorder, Route--PO or IV Adverse Reactions: drowsiness, ataxia, coma, paradoxical excitement, decreased resp., nausea and vomiting Contraindications: history of drug abuse, shock Drug Interactions: alcohol--increased anti-sedation, anticonvulsants--increased sedation, antidepressants--increased sedation, Nursing Implications: Assessment: drug history, V/S, observe or agitation Nursing Dx: potential for injury Interventions: fall precautions, give with meds; Evaluation: Teaching/Learning: take only as prescribed, avoid alcohol, avoid constipation, do not operate dangerous machinery Implications Across the Life Span: avoid in pregnancy, cause birth defects, children--paradoxical stimulation is common, elderly--increased sedative effects Toxicity: common, no antidote for barbiturate overdose. PROTOTYPE: Phenobarbital.	Pages 356-365
Identify appropriate nursing assessments, diagnosis, interventions, and evaluation of patients receiving sedatives. Develop a teaching/learning plan for patients receiving CNS sedatives.	Classification: Benzadiaze Pines (Anxiolytic) Action: alleviate anxiety without barbiturate-like sedation Indications & Administration: anticonvulsant, anxiety, musculoskeletal disorders, alcohol withdrawal, route--PO, IM, IV Adverse Reactions: (see barbiturate), dry mouth, urinary retention Contraindications: drug history, narrow angle glaucoma Drug	

Objectives	Outline	Learning Activity
Discuss the implications of sedative therapy across the life span.	Interactions: alcohol and Tagamet, CNS depression Nursing Implications: Assessment: drug history, V/S Nursing Dx: potential for injury Interventions: see barbiturates Evaluation: assess effectiveness Teaching/Learning: see barbiturates Implications Across Life Span: avoid in pregnancy, fetal deformities Toxicity: high margin of safety. PROTOTYPE: Diazepam (Valium).	
	SUBSTANCE ABUSE	
Identify 5 most commonly abused drugs.	Commonly Abused Drugs: 1) alcohol 2) opiates: morphine, heroin	Pages 529-541
Examine your definition of drug misuse, abuse, dependence.	3) caffeine 4) cocaine 5) cannabinoids Substance Abuse Definitions:	
Identify appropriate nursing assessments, diagnosis, interventions and evaluation for person with substance abuse problem.	1) misuse 2) abuse 3) dependency 4) physcial dependency 5) tolerance 6) withdrawal	
Develop teaching/learning plan for a person abusing a CNS depressant or stimulant.	Nursing Assessment: history of drug use, Nursing Dx: ineffective individual coping Interventions: monitor vital signs, symptoms of withdrawal Evaluation: tolerate withdrawal symptoms Teaching/	
Examine your responsibility as a professional nurse when dealing with an impaired nurse or other health care provider.	Learning: coping mechanisms, support groups Reporting Abuse of Substances:	

Objectives	Outline	Learning Activity
Identify the pharmacologic effects and mechanisms of selected anticonvulsant drugs. Identify the main clinical indications and administration of selected hydantoin drugs. Identify five adverse reactions, contraindications and drug interactions of anticonvulsants, hydantoin. Identify clients at risk of developing toxicity to hydantoin anticonvulsants. List the signs and symptoms of toxicity to hydantoin anticonvulsants. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving anticonvulsants. Develop a teaching/learning plan for patients receiving anticonvulsants. Examine the implications of anticonvulsant therapy across the life span. Identify adjunctive drugs for managing seizure activity.	Classification: Anticonvulsants (Hydantoins) Action: Suppress the start of seizures, reduce spread of seizures Indications and Administration: seizure activity, route PO IM IV (slowly) Adverse Reactions: sluggishness, leukopenia, gingival hyperplasia, rashes; IV hypotension, increase blood glucose, nausea, vomiting Contraindications: alcohol, bone marrow depression, bradycardia Drug Interactions: many drugs (alcohol, valium) increase effects, see Table 25-7 Nursing Implications: Assessment--be aware of potential of many drug interactions with phenytoin, seizure activity, therapeutic level mg/ml Nursing Diagnosis: potential impaired gas exchange Interventions: good oral care Evaluation: no seizure activity, no adverse reactions Teaching/Learning: take as prescribed, take with meals, diabetic changes Implications Across the Life Span: elderly CNS toxicity increased, pregnancy birth defects possible, children gingival hyperplasia increased. PROTOTYPE: Phenytoin (Dilantin)	Pages 481-495

Objectives	Outline	Learning Activity
Identify the pharmacologic effects and mechanisms of selected antiparkinson drugs. Identify the clinical indications and administration of dopaminergic drugs. Identify five adverse reactions, contraindications and drug interactions of dopaminergic drugs. Identify client's at risk of developing toxicity to dopaminergic agents. List the signs and symptoms of toxicity to dopaminergic agents. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving dopaminergic agents. Develop an Antiparkinson teaching/learning plan for patients receiving. Examine the implications of Antiparkinson therapy across the life span. Identify adjunctive drugs for managing Parkinsonism.	Classification: Antiparkinson Agents, Dopaminergic Agents Action: Levodopa changed to dopamine, carbidopa inhibits DOPA, decarboxylase in GI tract spares Levodopa Indications & Administration: Parkinsonism, PO route Adverse Reactions: headaches, blurred vision, hypotension, nausea, vomiting, bleeding, anorexia, choreiform movements Contraindications: narrow-angle asthma, peptic ulcer, CV disease Drug Interactions: antihypertensive - increase hypotension, antipsychotics - decreases antiparkinson effect Nursing Implications: **Assessment**--VS, adverse reactions, mental status **Nursing Diagnosis**-- **Interventions**--take between meals, check I & O **Evaluation**--decreased parkinson symptoms **Teaching/Learning**--stand slowly, remove hazards in environment **Implications Across the Life Span**--avoid in pregnancy and children. PROTOTYPE: Levodopa/Carbidopa.	Pages 452-464

Pharmacology
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bjectives	Outline	Learning Activity
Identify three classifications of psychoactive drugs: 1) antipsychotic 2) antidepressants 3) antimanic. Identify the pharmacologic effects and mechanisms of selected psychoactive drugs. Identify the clinical indications and administration of selected psychoactive drugs. Identify adverse reactions, contraindications, and drug interactions of selected psychoactive drugs.	Classification: Antipsychotic Action: blocks dopamine receptor sites Indication & Administration: schizophrenia, antiemetic PO & IM Adverse Reactions: Parkinsonism, hypotension, constipation Contraindications: Parkinsons Drug Interactions: alcohol--increase CNS depression, insulin--poor diabetic control Nursing Implications: Assessment: VS, drowsiness, Parkinsonism Nursing Dx: Alteration in thought processes Interventions: use lowest effective dose, high fiber diet Evaluation: more organized thinking Teaching/ Learning: adverse reactions, avoid alcohol Implications Across Life Span: avoid during pregnancy, elderly more susceptible to side effects. PROTOTYPE: Thorazine	Pages 389-412 420-430 431-440 442-446
Identify clients at risk of developing toxicity to psychoactive drugs. List the signs and symptoms of toxicity to psychoactive drugs. Identify appropriate nursing assessments, diagnosis, interventions, and evaluation of patients receiving psychoactive drugs. Develop a teaching/learning plan for patients receiving psychoactive agents. Discuss the implications of psychoactive therapy across the life span.	Classification: Tricyclic antidepressants Action: inhibit reuptake of neurotransmitters Indications & Administration: depression PO Adverse Reactions: sedation, dry mouth, blurred vision Contraindications: CHF, urinary retention Drug Interactions: oral contraceptives inhibit effects of tricyclics Nursing Implications: **Assessment**--side effects, bowel pattern; **Nursing Dx**--ineffective individual coping; **Interventions**--VS, avoid activities requiring alertness; **Evaluation**--Teaching/Learning: takes 2-4 weeks to feel antidepressant effects Implications Across the Life Span: avoid in pregnancy, children--used for enuresis, elderly--increase dose slowly. PROTOTYPE: Imipramine.	
	Classification: Monoamine Oxidase Inhibitor-Antidepressant Action: stops inactivation of	

neurotransmitters Indication: depression Adverse Reactions: blurred vision, atropine-like effects, hypotension, agitation Contraindications: hepatic or renal impairment Drug Interactions: methyldopa and sympathomimetics cause hypertensive crisis Nursing Implications: **Assessment**--side effects, VS-BP, CBC; **Nursing Dx**-- **Interventions**-- **Evaluation**--response to med; Teaching/Learning: avoid tyramine rich food, beer, cheese, chocolate Implications Across Life Span: elderly--CVD increase, avoid children and pregnancy Toxicity: overdoses a real possibility. PROTOTYPE: Marplan.

Classification: Antimanic-Lithium Action: reduce neurotransmitter release Indications & Administration: manic-depressive illness, PO Adverse Reactions: nausea, thirst, diarrhea, mild hand tremor Contraindications: renal, cardiovascular disease Drug Interactions: diuretics increase Lithium blood levels Nursing Implications: **Assessment**--signs for toxicity; **Nursing Dx**-- **Interventions**--check Lithium level, provide adequate salt diet, encourage fluids; **Evaluation**--response to drug; Teaching/Learning: toxicity sts., diet, avoid diuretics Implications Across Life Span: avoid--children & pregnancy, elderly--reduced dosages. PROTOTYPE: Lithium Carbonate.

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Course Syllabus/Outline

UNIT: DRUGS THAT AFFECT THE CARDIOVASCULAR AND RENAL SYSTEM

Objectives	Outline	Learning Activity
Identify three classifications of antianginals. Identify the pharmacologic effects and mechanisms of selected antianginal drugs. Identify the indications and administration of selected antianginal drugs. Identify the indications and administration of selected antianginal drugs. Identify adverse reacations, contraindications and drug interactions of selected antianginal drugs. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving antianginals.	ANTIANGINALS Classification: Organic nitrates Action: peripheral vasodilation Indications: angina pectoris Adverse Reactions: hypotension, flushing, headache Contraindications: hypotension, head-injury Drug Interactions: potentiate antihypertensives Nursing Implications: **Assessment**--chest pain, oxygenation; **Diagnosis**--alteration in comfort; **Interventions**--pain relief, promote oxygenation; **Evaluation**--pain relief Teaching/Learning: indication, administration Life Span: pregnancy-lactation; children, elderly Adjunctive Drugs: oxygen, analgesics PROTOTYPE: Nitroglycerin. Classification: Calcium channel blockers Action: interfere calcium influx and vessel contraction Indications: angina pectoris Adverse Reactions: constipation, AV block Contraindications: liver dysfunction Drug Interactions: potentiate antihypertensives Toxicity: bradycardia, AV block Nursing Implications: **Assessment**: chest pain, oxygenation; **Diagnosis**--alteration in comfort; **Interventions**--pain relief, promote oxygenation; **Evaluation**--pain relief Teaching/Learning: Life Span: pregnancy--lactation, children elderly Adjunctive Drugs: oxygen, analgesics PROTOTYPE: Verapamil. Classification: Beta-adrenergic blockers Action: block sympathetic stimulation PROTOTYPE: Inderal.	Shlafer, Ch 33, pp. 687-703

Objectives	Outline	Learning Activity
Identify four classifications of diuretics and five classifications of antihypertensives. Identify the pharmacologic effects and mechanisms of selected antihypertensive and diuretic drugs. Identify the indications and administration of selected antihypertensive and diuretic drugs. Identify adverse reactions, contraindications, and drug interactions of selected antihypertensive and diuretic drugs.	ANTIHYPERTENSIVES/DIURETICS Classification: Thiazides Action: inhibit tubular reabsorption of sodium and water Indications: essential hypertension, edema Adverse Reaction: hyponatremia, hypovolemia, hypokalemia Contraindication: hypokalemia Drug Interactions: antihypertensives, digitalis, antidiabetics Nursing Implications: **Assessment**--edema, electrolytes **Diagnosis**--alteration fluid volume **Interventions**--fluid management **Evaluation**--electrolyte levels Teaching/Learning: signs and symptoms of electrolyte disturbance, fluid management Life Span: pregnancy-lactation, children, elderly Adjunctive Drugs: antihypertensives, other diuretics. PROTOTYPE: Hydrochlorothiazides	Shlafer, Chap. 31, pp. 610-642 Shlafer, Chap. 32 pp. 645-684
Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving antihypertensives and diuretics. Develop a teaching/learning plan for patients receiving antihypertensives and diuretics. Contrast the implications of antihypertensive and diuretic therapy across the life span.	Classification: Loop Diuretics Action: inhibit sodium and water reabsorption in the loop of Henle Indications: chronic edema, acute pulmonary edema Adverse Reactions: hypotension, hyponatremia, hypovolemia, hypokalemia Contraindications: hypokalemia, hypotension Drug Interactions: antihypertensives, ASA Nursing Implications: **Assessment**--edema, electrolytes **Diagnosis**--fluid volume alteration **Interventions**--fluid management **Evaluation**--electrolyte levels, monitor BP Teaching/Learning: signs and symptoms of electrolyte disturbance, fluid management Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Furosemide.	
Identify adjunctive drugs for managing hypertension and edema.	Classification: Potassium-sparing diuretics Action: inhibit sodium reabsorption in the distal tubules Indications: edema, hypertension Adverse Reactions: hyponatremia, hypovolemia, hyperkalemia Contraindications: hyperkalemia Drug Interactions: antihypertensives	

Objectives Outline Learning Activity

antibiotics Nursing Implications: **Assessment**--edema, electrolytes **Diagnosis**--fluid volume alteration **Interventions**--fluid management **Evaluation**--BP, electrolyte levels Teaching/Learning: signs, symptoms electrolyte disturbance, fluid management Life Span: Pregnancy/lactation, children, elderly.
PROTOTYPE: Triamterene

Classification: Osmotic Diuretics Action: increases renal blood flow and glomerular filtration Indications: renal failure, cerebral edema Adverse Reactions: acute pulmonary edema, hypertension, electrolyte depletion Contraindications: renal failure Nursing Implications: **Assessment**--edema, hypertension **Diagnosis**--alteration in fluid volume **Interventions**--fluid management **Evaluation**--electrolyte levels Teaching/Learning: fluid management.
PROTOTYPE: Mannitol.

Classification: Centrally Acting Alpha Adrenergic Agonists Action: stimulate alpha receptors in the brain Indications: moderate hypertension Adverse Reactions: dry mouth, drowsiness, hypotension Contraindications: hypotension Drug Interactions: cardiac meds Nursing Implications: **Assessment**--hypertension **Interventions**--BP regulation **Evaluation**--BP Teaching/Learning: BP control, don't withdraw suddenly Life Span: Pregnancy/lactation, children, elderly Adjunctive Drugs: antihypertensives, diuretics.
PROTOTYPE: Clonidine.

Classification: Peripherally Acting Alpha-Adrenergic Blockers Action: blocks postsynaptic alpha receptors Indications: hypertension especially related to pheochromocytoma Adverse Reactions: postural hypotension

Objectives Outline Learning Activity

Contraindications: hypotension Drug Interaction: antihypertensives Nursing Implications: **Assessment**: BP, **Interventions**--BP regulation, **Evaluation**: BP Teaching/Learning: hypotension Life Span: pregnancy/lactation, children, elderly.
PROTOTYPE: Prazosin.

Classification: Peripherally Acting Catecholamine Depleters Action: block norepinephrine storage Indications: hypertension, agitated psychosis Adverse Reactions: hypotension, water retention Contraindication: GI and GB disease Drug Interactions: Antihypertensives, catecholamines Nursing Implications: **Assessment**--BP, **Interventions**--diet management, BP regulation, **Evaluation**--BP Teaching/Learning: BP control Life Span: pregnancy/lactation, children, elderly.
PROTOTYPE: Reserpine.

Classification: Vasodilators Action: directly dilates arterioles Indications: hypertension especially in association with poor renal function Adverse Reactions: tachycardia, palpitation Contraindications: pheochromocytoma Drug Interactions: antihypertensives Nursing Implications: **Assessment**--BP, **Diagnosis**--alteration cardiac output, **Evaluation**--BP Teaching/Learning: hypotension Life Span: pregnancy/lactation, children, elderly.
PROTOTYPE: Hydralzaine.

Classification: Angiotensin Converting Enzyme Inhibitors Action: indirectly reduce aldosterone levels Indications: hypertension Adverse Reactions: hypotension Contraindications: hypotension, hyperkalemia Drug Interaction: antihypertensives Nursing Implications: **Assessment**--BP,

Objectives	Outline	Learning Activity
	Evaluation: BP Teaching/Learning: BP management Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Captopril.	
Identify five classifications of antiarrhythmics. Identify the pharmacologic effects and mechanisms of selected antiarrhythmic drugs. Identify the clinical indications and administration of selected antiarrhythmic drugs. Identify adverse reactions, contraindications and drug interactions of selected antiarrhythmic drugs. Identify clients at risk of developing toxicity to antiarrhythmic drugs. List the signs and symptoms of toxicity to lidocaine and digitalis. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving antiarrhythmics. Develop a teaching/learning plan for patients receiving antiarrhythmics Contrast the implications of antiarrhythmic therapy across the life span.	ANTIARRHYTHMICS Classification: Class IA Agents Action: suppress automaticity Indications: atrial arrhythmias Adverse Reactions: cardiac depression Contraindications: AV block, CHF Drug Interactions: Digoxin effectiveness decreased Toxicity: cardiac depression Nursing Implications: **Assessment**--cardiac function; **Interventions**--improve cardiac function; **Evaluation**--drug levels Teaching/Learning: Life Span: pregnancy-lactation, elderly Adjunctive Drugs: antiarrhythmics. PROTOTYPE: Quinidine. Classification: Class IB Agents Action: suppress ventricular arrhythmias Indications: ventricular arrhythmias Adverse Reactions: heart block, hypersensitivity Toxicity: convulsions, CNS depression Nursing Implications: **Assessment**--cardiac function; **Interventions**: cardiac monitoring; **Evaluation**: drug levels Teaching/Learning: Life Span: pregnancy-lactation, children, elderly Adjunctive Drugs: antiarrhythmics. PROTOTYPE: Lidocaine. Classification: Class IC Agents Action: reduce myocardial repolarization. PROTOTYPE: Ecainimide. Classification: Class II Agents Action: Beta adrenergic blockers. PROTOTYPE: Inderal. Classification: Class III Agents Action: prolong action potential. PROTOTYPE: Amiodarone, Bretyllium.	Shlafer Ch. 29, 30 pp. 561-608

Objectives	Outline	Learning Activity
Identify adjunctive drugs for managing heart failure.	Classification: Class IV Agents Action: Calcium channel blockers PROTOTYPE: Diltiazem, Nifedipine, Verapamil. Classification: Miscellaneous Agents Action: increase myocardial contractility and alter conduction Indications: congestive heart failure, arrhythmias Adverse Reactions: arrhythmias, GI, cardiac Contraindications: toxicity, bradycardia, AV block Toxicity: cardiac arrhythmias Nursing Implications: **Assessment**--heart rate, cardiac function; **DX**--cardiac output, fluid volume excess; **Interventions**--promote cardiac output; **Evaluation**--cardiac output, drug levels Teaching/Learning: pulse variations, signs and symptoms of toxicity Life Span: pregnancy-lactation, children, elderly Adjunctive Drugs: diuretics, antihypertensives. PROTOTYPE: Digoxin.	
Identify four classifications of drugs affecting coagulation. Identify the pharmacologic affects and mechanisms of selected drugs affecting coagulation. Identify the clinical indications and administration of selected drugs affecting coagulation. Identify adverse reactions, contraindications and drug interactions of selected drugs affecting coagulation.	COAGULATION Classifications: Parenteral Anticoagulants Action: interfere with coagulation pathway Indications: prophylaxic, thrombosis, cardiac surgery Adverse Reactions: hemorrhage Contraindications: patients with high risk of bleeding Drug Interactions: other anticoagulants Toxicity: managed with protamine sulfate Nursing Implications: **Assessment**--APTT, signs and symptoms of bleeding; **Interventions**--promote safety; **Evaluation**--dosage regulation with PTT Teaching/Learning: watch for bleeding Life Span: pregnancy-lactation, children, elderly. PROTOTYPE: Heparin. Classification: Oral Anticoagulants Action: interfere with coagulation pathway Indications: thrombosis, embolism Adverse Reactions:	Shlafer, Ch. 34 pp. 705-724

Objectives	Outline	Learning Activity
Identify clients at risk of developing toxicity to drugs affecting coagulation. List the signs and symptoms of toxicity to drugs affecting coagulation. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving drugs which affect coagulation. Contrast the implications of therapy across the life span for patients on drugs which affect coagulation. Identify adjunctive drugs for managing clotting disorders.	hemorrhage Contraindications: patients with high risk of bleeding Drug Interactions: additive with other anticoagulants Toxicity: managed with Vitamin K Nursing Implications: **Assessment**--PT, signs and symptoms of bleeding; **Interventions**--promote safety; **Evaluation**--dosage regulation with PT; Teaching/Learning: watch for bleeding Life Span: pregnancy-lactation, children, elderly. PROTOTYPE: Warfarin. Classification: Thrombolytic Drugs Action: lysis of clots Indications: lysis of pulmonary, cardiac systemic thrombi Adverse Reactions: hemorrhage Contraindications: intracranial and internal bleeding and other patients with high risk of bleeding Drug Interactions: anticoagulants Toxicity: managed with aminocaproic acid Nursing Implications: **Assessment**--signs and symptoms of bleeding, coagulation profiles; **Diagnosis**--potential for injury; **Interventions**--promote safety; **Evaluation**--on dosage regulation with coagulation profiles Teaching/Learning: watch for bleeding Life Span: pregnancy-lactation, children. PROTOTYPE: Streptokinase. Classification: Antiplatelets Action: inhibit platelet aggregation. PROTOTYPE: Aspirin.	

Objectives	Outline	Learning Activity
Identify three classifications of drugs which affect body lipids. Identify the pharmacologic effects and mechanisms of selected drugs which affect body lipids. Identify the clinical indications and administration of selected drugs which affect body lipids. Identify adverse reactions, contraindications and drug interactions of selected drugs which affect body lipids. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving drugs which affect body lipids. Develop a teaching/learning plan for patients receiving drugs which affect body lipids. Contrast the implications of therapy across the life span for patients receiving drugs which affect body lipids. Identify adjunctive drugs for managing hyperlipidemia.	BODY LIPIDS Classification: Serum Cholesterol Reducers Action: sequesters bile acids Indications: hypercholesterolemia Adverse Reactions: constipation Contraindications: constipation and malnourished patients Drug Interactions: binds many oral medications Nursing Implications: **Assessment**--nutritional and GI status; **Diagnosis**--alteration in nutrition; **Interventions**--proper nutrition **Evaluation**--reduction of serum cholesteral levels Teaching/Learning: nutrition Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Cholestyramine. Classification: Serum Triglyceride Reducers Action: inhibit VLDL Indications: hyperlipoprotenemia Adverse Reactions: GI upset, gallstone formation Contraindications: liver and renal disease Drug Interactions: potentiate anticoagulants Nursing Implications: **Assessment**--nutritional and GI status **Diagnosis**--alteration in nutrition **Interventions**--proper nutrition **Evaluation**--reduction of serum triglyceride levels Teaching/Learning: nutrition Life Span: pregnancy/lactation. PROTOTYPE: Clofibrate	Shlafer, Chapter 35 pp. 729-739

UNIT: DRUGS THAT AFFECT RESPIRATORY SYSTEM

Objectives	Outline	Learning Activity
Identify four classifications of drugs used to manage asthma. Discuss the pharmacologic effects and mechanisms of each classification of anti-asthmatic drugs. Identify the clinical indications and administration of each classification of anti-asthmatic drugs. Identify adverse reactions, contraindications, and drug interactions of prototype antiasthmatic drugs. Identify prototype drugs of each classification of antiasthmatic drugs. Identify appropriate nursing assessments, diagnosis, interventions, and evaluation of patients receiving antiasthmatic drugs. Develop a teaching/learning plan for patients receiving antiasthmatic drugs. Discuss the implications of antiasthmatic therapy across the life span.	Classification/Mechanism: Bronchodilators, Methylxanthines, Theophylline Mast Cell Stablizier: Cromolyn Mucolytic/Expectorants: Aceteylcysteine (Mucmyst) Orally Inhaled Expectorants: Beclomethasome (Vanceril) Adverse Reactions: Assessments: respirations, cough sputum, vital signs, activity tolerance, smoking Teaching/Learning: use of nebulizers, oral hygiene, self-medication with OTC drugs, SIS adrenal insufficiency, effective cough and deep breathing, SIS to report Life Span: children, elderly, pregnancy.	Schlafer, Ch. 37

UNIT: DRUGS THAT AFFECT AUTONOMIC NERVOUS SYSTEM

Objectives	Outline	Learning Activity
Identify two classifications of neuromuscular drugs. Discuss the pharmacologic effects and mechanisms of ganglionic blocking and stimulated drugs. Identify the clinical indications and administration of neuromuscular blocking and stimulant agents. Identify adverse reactions, contraindications, and drug interactions of selected neuromuscular drugs. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving ganglionic blocking agents. Develop a teaching/learning plan for patients receiving neuromuscular blocking agents. Discuss the implications of neuromuscular therapy across the life span.	Classification: 1) ganglionic blockers 2) ganglionic stimulants Pharmacologic Mechanisms: 1) ganglionic blocking agents prototype--Trimethaphan 2) ganglionic stimulants prototype--Nicotine polacrilex (Nicorette) Clinical Indications: Ganglionic Blocking Agents: 1) controlled hypotension during surgery 2) hypertensive crisis 3) adjunctive therapy of acute pulmonary edema Ganglionic Stimulants: 1) aid to quit smoking Adverse Reactions: 1) ganglionic blocking--hypotension 2) ganglionic stimulants--toxicity Nursing Assessments: Teaching/Learning: action, side effects (orthostatic hypotension, sexual dysfunction) Life Span: children, elderly, pregnancy.	Required reading to be announced
Identify five classifications of drugs that affect the autonomic and somatic nervous system. Discuss the pharmacologic effects and mechanisms of selected autonomic & somatic nervous system drugs, giving an example of each classification.	Classification: 1) parasympathomimetic cholinergic 2) acetylcholinesterace 3) anticholinergic 4) sympathomimetic 5) adrenergic receptors Pharmacologic Mechanisms: parasympathomimetic prototype--acetycholine Related Drugs: Bethanechol, Methacholine, Pilocarpine Acetylcholine Inhibitors: prototype--neostigmine Related: Tensilion Edrophonium, Physostigmine (antilirium), Pyridostigmine (mestinon) Anticholinergic: prototype--Atropine Related: Propantheline (Pro-Banthine), Scopolamine hydrobromide, Belladonna alkaloid, Clidinium bromide (Librax) Sympathomimetic Drugs: prototypes--Alpha Beta Agonist: (Epinephrine, Levophed, Norepinephrine), (Phenylephrine), Beta Agonist: (Isoproterenol); Beta$_1$ Agonists:	

Objectives	Outline	Learning Activity
Identify the clinical indications and administration of each classification of selected autonomic and somatic nervous system drugs. Identify adverse reactions, contraindications and drug interactions of selected autonomic and somatic nervous system drugs. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving autonomic and somatic nervous system drugs. Develop a teaching/learning plan for patients receiving autonomic and somatic nervous system drugs. Discuss the implications of autonomic and somatic nervous system therapy across the life span.	Dobitamine (Dobutrex), Dopamine Hydrochloride (Intropine); Beta_2 Agonists: Albuterol Sulfate (Proventil), tertuilaline sulfate (Brethine), Adrenic Blocking Agents Alpha Adrenergic Blocking Agents: Prototype--Phenlolamine (Regitini) Related: Prozosine (minipress); Beta Blocking Agents: PROTOTYPES: Propranolol, Metroprolol.	

UNIT: DRUGS THAT AFFECT GASTROINTESTINAL TRACT

Objectives	Outline	Learning Activity
Identify the drugs that are used in the management of common GI tract disorders: ulcers and hyperacidity, constipation, diarrhea, vomiting. Identify the pharmacologic effects and mechanisms of selected gastrointestinal drugs. Identify the clinical indications and administration of selected gastrointestinal drugs. Identify five adverse reactions, contraindications, and drug interactions of selected gastrointestinal drugs. List the signs and symptoms of toxicity to gastrointestinal drugs. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving gastrointestinal drugs. Develop a teaching/learning plan for patients receiving gastrointestinal drugs. Contrast the implications of gastrointestinal therapy across the life span.	ULCER AND HYPERACIDITY Classifications: antacid/antacid combination Action: neutralize gastric acid, aluminum hydroxide, magnesium hydroxide, calcium carbonate, sodium bicarbonate Indications and Administration: ulcers and hyperacidity, oral route or NG tube Adverse Reactions: acid-base imbalance, altered gut motility, constipation or diarrhea Contraindications: edema, CHF, current diarrhea, constipation Drug Interactions: used with tetracycline, phenothiazine, digoxin, beta blockers --> decreased absorption Nursing Implications: **Assessment**--pain, GI bleed, constipation, diarrhea; **Dx**--alteration comfort, alteration in bowel elimination; **Interventions**--stress frequent use, take as long as directed by MD; **Evaluation**--pain relief, decreasing size of ulcer; Teaching/Learning: stress relaxation (see interventions) Implications Across the Life Span: elderly--lower doses, pregnancy--used properly, safe. PROTOTYPE: Riopan (combination of aluminum and magnesium). Classification: histamine blockers Action: block effect of histamine on histamine sites, eliminate stimulus for acid secretion Indications and Administration: ulcers oral, I.M. or I.V. Adverse Reactions: confusion, decreased sperm count Contraindications: none Drug Interactions: may elevate blood levels of propranolol, lidocaine and morphine Nursing Implications: **Assessment**--assess patients with poor renal or hepatic function; **Dx**--alteration	Chapter 39, pgs. 784-798

Objectives	Outline	Learning Activity
Identify for adjunctive drugs for managing gastrointestinal disorders.	in comfort **Interventions**--cimetidine may cause false positive hemocult for gastric juices if given 15 minutes before test; **Evaluation**--relief of pain Teaching/Learning: stress relaxation techniques Implications Across Life Span: avoid in pregnancy, lactation, reduced doses in elderly Toxicity: rare tachycardia, respiratory depression. PROTOTYPE: Cimetidine.	
	CONSTIPATION Major classes of laxatives and cathartics Action: 1) bulk forming--absorb water 2) hyperosmotic--local osmotic action 3) lubricant 4) saline--osmotically withdraws water 5) stimulant--stimulates motility 6) stool softeners--reduce surface tension of stool Indications: constipation bowel cleansing prior to surgery, oral; #5 oral or rectal suppository enema Contraindications: diarrhea, gut weakness or obstruction, #4 renal failure Adverse Reactions: fluid, electrolyte loss, diarrhea Drug Interactions: increased motility decrease time for other drug absorption Nursing Implications: **Assessment**--normal bowel pattern, eating habits; **Dx**--alteration bowel elimination; **Interventions**--observe for side effects; **Evaluation**--regular bowel pattern Teaching/Learning: diet, exercise, side effects of laxatives Implications Across Life Span: #4 avoid in elderly if possible, children under 5 and pregnancy, #3 avoid in pregnancy. PROTOTYPES: 1) metamucil 2) glycerin 3) mineral oil 4) milk of magnesia 5) dulcolax 6) colace	Pages 804-816

bjectives	Outline	Learning Activity
	ANTIDIARRHEALS Classification: 1) absorbents--bind noxious substances 2) opiates--antispasmodic action 3) anticholinergics--antispasmodic Indications and Administration: diarrhea Adverse Reactions: constipation, #3 dry mouth, blurred vision tachycardia Contraindications: gut obstruction, constipation, #3 glaucoma, #2 drug history Nursing Implications: **Assessment**--normal bowel pattern, bowel sounds; **Dx**--alteration bowel elimination; **Interventions**--give #1 type after every loose stool, monitor, #2 for CNS depression; **Evaluation**--normal bowel pattern; Teaching/Learning: side effects Implications Across Life Span: PROTOTYPE: 1) Pepto-Bismol 2 and 3) Lomotil.	Pages 816-819
	Classification: Emetics Action: stimulating CTZ and local irritation of GI tract Indications: induce vomiting Adverse Reactions: hypotension, severe retching Contraindications: fluid and electrolyte imbalance, epilepsy or seizure disorder Drug Interactions: avoid use with antiemetics Nursing Implications: **Assessment**--ingestion of toxic substance, CNS checks, vital signs; **Dx**--alteration in comfort; **Interventions**--position person on side to decrease risk of aspiration; **Evaluation**--vomitas; Teaching/Learning: keep dose available at home Implications Across Life Span: PROTOTYPE: Ipecac.	

UNIT: HORMONES, HORMONE ANTAGONISTS AND OTHER DRUGS THAT AFFECT ENDOCRINE SYSTEM

Objectives	Outline	Learning Activity
Identify three classifications of drugs which affect glucose levels. Identify the pharmacologic effects and mechanisms of selected drugs which affect glucose levels. Identify the clinical indications and administration of selected drugs which affect glucose levels. Identify adverse reactions, contraindications, and drug interactions of selected drugs which affect glucose levels. Identify clients at risk of developing toxicity to drugs which affect glucose levels. List the signs and symptoms of toxicity to drugs which affect glucose levels. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving drugs which affect glucose levels. Develop a teaching/learning plan for patients receiving drugs which affect glucose levels.	Classification: Insulins Action: restore ability to metabolize carbohydrates Indications: diabetes mellatus, hyperkalemia Adverse Reactions: hypo/hyperglycemia Contraindications: hypoglycemia Drug Interactions: beta blockers, alcohol, ASA Nursing Implications: **Assessments**--signs and symptoms of hypo/hyperglycemia; **Dx**--nutrition, alteration in; **Interventions**--proper nutrition and insulin regulation; **Evaluation**--glucose levels Teaching/Learning: nutrition, signs and symptoms of hypo/hyperglycemia Life Span: pregnancy-lactation, children, elderly. PROTOTYPE: Insulin. Classification: Oral Hypoglycemics Action: increase pancreatic insulin release Indications: diabetes mellitus Adverse Reactions: GI disturbance Contraindications: Type I diabetes Drug Interactions: insulin, ASA, NSAIA Nursing Implications: **Assessment**--signs and symptoms; **Dx**--nutrition, alteration in; **Interventions**--monitor for signs; **Evaluation**--monitor glucose levels Teaching/Learning: nutrition, symptoms of hypo/hyperglycemia Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Tolbutamide. Classification: Hyperglycemics Action: stimulates glycogenolysis Indication: hypoglycemia Adverse Reactions: allergic reactions, GI upset Contraindications: patients with insulin secreting tumors Drug Interactions: diuretics Nursing Implications: **Assessment**--	Shlafer, Chapter 45 pp. 910-936

Objectives	Outline	Learning Activity
Contrast the implications of therapy across the life span for patients receiving drugs which affect glucose levels. Identify adjunctive drugs for managing diabetes.	nutritional status; **Evaluation**--monitor glucose and electrolyte levels; Teaching/Learning: hypo/hyperglycemia, nutrition Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Glucagon.	
	HORMONALS	
Identify six classifications of hormonal agents. Identify the pharmacologic effects and mechanisms of selected hormonal drugs. Identify the clinical indications and administration of selected hormonal drugs. Identify adverse reactions, contraindications and drug interactions of selected hormonal drugs. Identify appropriate nursing assessments, diagnosis, interventions and evaluation of patients receiving hormonal agents. Develop a teaching/learning plan for patients receiving hormonal agents.	Classification: Thyroids Action: cellular metabolism Indications: replacement therapy Adverse Reactions: hyperthyroidism Contraindications: uncontrolled adrenal insufficiency Drug Interactions: oral anticoagulants, hypoglycemics Nursing Implications: **Assessment**--signs and symptoms of hyperthyroidism; **Interventions**--monitor for side effects; **Evaluation**--monitor thyroid levels; Teaching/Learning: hyperthyroidism Life Span: pregnancy-lactation, children, elderly. PROTOTYPE: Synthroid. Classification: Antithyroid Agents Action: inhibit functional thyroid synthesis Indications: hyperthyroidism Adverse Reactions: leukopenia, hypersensitivity Contraindications: allergy Drug Interactions: anticoagulants, ASA Nursing Implications: **Assessment**--symptoms of hyperthyroidism; **Interventions**--monitor side effects **Evaluation**--T3 and T4 level Teaching/Learning: signs/symptoms hypo/hyperthyroidism Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Propylthiouracil. Classification: Androgens Action: promote sex organ and sex characteristic development Indications: replacement therapy, infertility, breast CA Adverse Reactions: edema, liver damage, hypercalcemia,	Shlafer, Chapter 46, pp. 942-964 Shlafer, Chapter 47, pp. 966-978 Shlafer, Chapter 48, pp. 983-1027

gynecomastia Contraindications: CHF, renal disease Drug Interactions: anticoagulants, hypoglycemics Nursing Implications: **Assessment**--signs/symptoms adverse reactions; **Dx**--sexuality dysfunctions; **Interventions**--watch side effects; **Evaluation**--monitor Hgb, Hct, CA, and side effects Teaching/Learning: adverse effects, increase fluid intake, medic alert tag Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Testosterone.

Classification: Ovarian Hormones Action: secondary sex characteristics stimulation, stimulation of endometrium Indications: replacement therapy Adverse Reactions: breast CA, hypertension, thrombophlebitis Contraindications: Nursing Implications: **Assessment**--assess spotting; **Dx**--self-concept, disturbance in body image; **Evaluation**--monitor adverse reactions Teaching/Learning: drug interactions with BCPs Life Span: pregnancy/lactation, children. PROTOTYPE: Estrogen.

Classifiction: Oral Contraceptives Action: suppress ovulation Indications: pregnancy prevention Adverse Reactions: weight gain, acne, fatigue Contraindications: smokers Drug Interactions: antibiotics, anticoagulants, antidiabetics Nursing Implications: **Assessment**--adverse effects; **Dx**--knowledge deficit; **Evaluation**--monitor side effects, BP Teaching/Learning: regimen compliance Life Span: PROTOTYPE: Estrogen-progesterone combination.

Classification: Fertility Drugs Action: stimulate gonadotropin

bjectives	Outline	Learning Activity
	secretion Indication: infertility Adverse Reactions: breast tenderness, GI disturbance Contraindications: hepatic dysfunction Nursing Implications: **Assessment**--knowledge level; **Dx**--knowledge deficit; **Evaluation**--pregnancy Teaching/Learning: multiple births. PROTOTYPE: Clomiphene.	
	Classification: Uterine Stimulants Action: stimulate uterine contractions Indications: labor induction Adverse Reactions: PVCs, arrhythmias, hemorrhage Contraindications: CPD Drug Interactions: vasoconstrictors, ASA Nursing Implications: **Assessment**--L and D stage, vag. delivery; **Intervention**--L and D assistance, monitor BP; **Evaluation**--contractions Teaching/Learning: Life Span: pregnancy. PROTOTYPE: Oxytocin.	
Identify two classifications of corticosteroids. Identify the pharmacologic effects and mechanisms of selected corticosteroid drugs. Identify the clinical indications and administration of selected corticosteroid drugs. Identify adverse reactions, contraindications and drug interactions of selected corticosteroid drugs.	STEROIDS Classification: Glucocorticoids Action: metabolic and anti-inflammatory effects Indications: replacement therapy, inflammation, etc. Adverse Reactions: iatrogenic Cushing's symptoms, GI upset Contraindications: viral/fungal infections Drug Interaction: alcohol, ASA, antacids Nursing Implications: **Assessment**--GI status, Cushing's symptoms; **Dx**--infection potential; **Interventions**--symptom management; **Evaluation**--symptom evaluation Teaching/Learning: Cushingoid symptoms, uninterrupted therapy Life Span: pregnancy/lacatation, children, elderly. PROTOTYPE: Cortisol.	Shlafer, Chapter 44 pp. 880-901
Identify appropriate nursing assessments, diagnosis, interventions and evaluation of	Classification: Mineralocorticoids Action: sodium absorption, potassium excretion Indication:	

Objectives	Outline	Learning Activity
patients receiving corticosteroid therapy. Develop a teaching/learning plan for patients receiving corticosteroid therapy. Contrast the implications of corticosteroid therapy across the life span. Identify adjunctive drugs for managing steroidal hyper/hyposecretion syndromes.	replacement therapy Adverse Reactions: hypernatremia, hypokalemia, hypertension Contraindications: hypertension, cardiac disease Drug Interactions: diuretics Nursing Implication: **Assessment**--nutritional and electrolyte status **Diagnosis**--fluid volume excess **Interventions**--symptom management **Evaluation**--serum electrolytes Teaching/Learning: symptoms of electrolyte imbalance Life Span: pregnancy/lactation, children, elderly. PROTOTYPE: Desoxycorticosterone.	

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

PHARMACOLOGY
Assignment: Consumer Information

1. Select an article which is published in a consumer publication such as, Parents Magazine, the newspaper, or Reader's Digest concerning any drug.
2. Critique the article on accuracy, relevancy, and thoroughness.
3. Discuss the impact this article will have on the consumer.
4. Your paper should be one to two typed pages and include a copy of your article with the paper.

DUE DATE TO BE ANNOUNCED.

KF/1-90/bh
Pharm/ConsInfo.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

PHARMACOLOGY
Drug Measurement and Calculation

Unit	Abbreviation	Equivalents
HOUSEHOLD		
liquid		
drop	gtt	
teaspoon	t or tsp	*1 t = 5 ccs
tablespoon	T or Tbsp	*1 T = 3 t = 15 ccs
weight		
pound	lb	*2.2 lbs = 1 kg
APOTHECARY		
liquid		
minim	m	* m xv (15) = 1 cc = 1 ml
dram		* i = 5 ccs
ounce		* i = 30 ccs
weight		
grain	gr	*gr i = 60 mg *gr 15 = Gm 1
METRIC		
liquid		
milliliter	ml	1 ml = 0.001 L
cubic cintimeter	cc	1 cc = 1 ml
liter	L	*1 L = 1000 ml = 1000 cc
weight		
microgram	mcg	*1000 mcg = 1 mg
milligram	mg	1 mg = 0.001 gm
gram	gm	1 gm = 1000 mg
kilogram	kg	1 kg = 1000 gm
TWO OTHER UNITS		
milliequivalents	mEq	
units	U	

Conversion from one system to another:

1. recall the equivalents.
2. multiply to convert to a smaller unit **OR** divide to convert to a larger unit.

Drug Measurement and Calculation

1. gr vi = ____________ mg
2. gr ss = ____________ mg
3. gr iss = ____________ mg
4. ii = ____________ cc
5. iiss = __________ cc

6. order: Phenobarbital 10 mg
supply 20 mg in 5 ccs
you will give _______ ccs

7. order: Gantrisin 750 mg
supply 0.5 gm tablets
you will give _______ tabs

8. order: Keflex 2 gm
supply: gr xv = i
you will give _______ ccs

9. order: Streptomycin 500 mg
supply: 1 gm = 2 ccs
you will give _______ ccs

10. order: Heparin 4,500 U
supply: 10,000 U = 1 cc
you will give ______ ccs

11. order: Digoxin 125 mcg
supply: .25 mg tabs
you will give _______ tabs

12. order: KCL 60 mEq
supply: 40 mEq = 10 ccs
you will give ________ ccs

Calculate the correct number of tablets or capsules to be administered per dose?

13. The physician writes an order for Coumadin gr 1/6. The drug container label reads Coumadin 5 mg. tablets.

14. Gantrisin 0.5 Gm tablets. Give gr xv.

15. Nicotinic acid 100 mg tablets. Give 0.3 Gm.

16. Orinase 500 mg tablets. Order: give Orinase 2 Gm after breakfast, 0.5 Gm after lunch and dinner. How many tablets are to be given after each meal?

17. From a streptomycin solution containing 500 mg in 1 cc, give 400 mg.

18. From a cortisone acetate solution containing 25 mg. in 1 cc, give 90 mg.

19. From digitoxin 0.2 mg per cc, give 0.3 mg.

20. Give cafeine sodium benzoate gr. 3 3/4 from solution labeled 0.5 Gm in 2 cc.

Practice Problems

1. From resurpine 0.25 mg., give 0.5 mg.

2. On hand, codeine sulfate 30 mg. Give 60 mg.

3. Give caffeine 0.2 Gm from tablets gr .

4. Gantrisin tablets on hand, gr . How will you give 1 Gm?

5. How will you give atropine sulfate gr 1/200 from tablet 0.3 mg?

6. Give phenobarbital gr from tablet 15 mg.

7. How will you give gr 1/6 of a drug from tablets labeled 10 mg?
8. From a streptomycin solution containing 500 mg in 1 cc, give 400 mg.
9. The vial on hand is labeled: "Morphine sulfate. minum xxx = gr 1/8". Give gr 1/24 of morphine sulfate.
10. From a cortisone acetate solution containing 25 mg. in 1 cc, give 90 mg.
11. The stock solution is labeled: "Demerol: 1 cc = 50 mg". Give 75 mg of demerol.
12. From scopolamine 0.4 mg per ml, give gr 1/300.
13. Give chlorpromazine 0.50 Gm from solution labeled 25 mg per ml.
14. From digitogin 0.2 mg per cc, give 0.3 mg.
15. Give caffeine sodium benzoate gr 3 3/4 from solution labeled 0.5 Gm in 2 cc.

Calculate the correct number of tablets or capsules to be administered per dose.

1. The physician writes an order for Coumadin gr 1/6. The drug container label reads Coumadin 5 mg tablets.
2. Gantrisin 0.5 Gm tablets. Give gr xv.
3. Nicotinic acid 10 mg tablets. Give 0.3 Gm.
4. Orinase 500 mg tablets. Order: give Orinase 2 Gm after breakfast, 0.5 Gm after lunch and dinner. How many tablets are to be given after each meal?
5. Order: Digoxin: 0.125 mg po
   Supply: Digoxin: 0.25 mg tablets
   Calculate the amount you will prepare for each po dose.
6. Order: Codeine 30 mg SC q 4 hrs prn pain.
   Supply 20 ml vial codeine labeled gr i in 1 ml.
7. Order: Aminophylline 0.5 Gm IM gid prn.
   Supply 2 cc ampule containing Aminophylline gr viiss.
8. Order Cleocin 300 mg IM bid.
   Supply: Cleocin 0.6 Gm = 4 cc.
9. Order: Dilantin 25 mg IM q 8 hr.
   Supply: Dilantin 100 mg/2 cc ampule.
10. Order: KCl 60 mEq IV.
    Supply: KCl 40 mEq = 10 ml.

KF/1-90/bh
DrugMeas.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

PHARMACOLOGY
Medication Calculation

Conversions:

1. 110 lbs = ________ Kg
2. 80 Kg = _________ lbs.
3. 80 cc = _________
4. gr vi = _______ mg
5. 150 mcg = _________ mg
6. gr 1/6 = ________ mg
7. Order: Thorazine 80 mg I.M.
   Dose on hand: 100 mg/2 cc
   How much do you give?

8. Order: Scopalamine .4 mg SQ
   Vial labeled: gr 1/150/ml
   How many ccs do you give?

9. Order: 2000 cc Lactated Ringers over 24 hours.
   How many ccs per hour? __________
   How many gtts per minute? _________
   Drop factor 15 gtts/ml.

10. Order: Erythromycin .4 Gm I.V.
    Drug supplied is 500 mg per 10 cc.
    Give ____________________

Pharmacology
Medication Calculation

11. Order: Hydrocortisone 75 mg I.M.
Supply: Hydrocortisone 100 mg/3 cc
Give ________________

12. Thiosulfil 0.5 Gm is ordered.
Tablets on hand are 250 mg.
You will give _________ tablets.

13. Order: Atropine gr 1/100 IM
Supply: Atropine .4 mg per ml.
You will give ____________ ml.

14. You have a vial of Potassium Penicillin G 1,000,000 units.
To provide 200,000 units per ml you need to add 9.6 ml of sterile water.
Your patient is to receive 500,000 units.
You will administer __________ ml.

15. Give 2500 ml NS over 24 hours.
Drop Factor is 10 gtts/ml.

16. Aminophyllin 250 mg. in 500 cc.
Infuse at 40 cc an hour.
How many mgs are you giving an hour?

Pharmacology
Medication Calculation

17. Order: Digitalis gr i ss po.
Supply: Digitalis 100 mg/tablet.
Give ____________ tablets.

18. Order: Diuril 250 mg po.
Supply: Diuril 0.5 Gm/tablet
Give _____________ tab.

19. Order: Klorvess 30 mEq po
Supply: Klorvess 20 mEq/15 ml
Give ______________ ml.

20. Order: 650 cc D_5W in 3 hours.
Drop Factor: 10 gtt/ml
Calculate flow rate in gtt/min.

21. Staphcillin 500 mg in 50 ml/NS I.V. at 10 cc/min
Drop Factor: 15 gtt/ml

22. Order: Heparin 30,000 u in 250 ml D_5W IV to infuse at 10 ml hr (via pump).
Label: Heparin 20,000 u/ml
Drop Factor: 60 gtt/ml

a) How many ml of Heparin should be added to the I.V. solution?

b) What should the flow rate be[illegible]

23. Order: Gantrisin Pediatric Suspension 150 mg/Kg po in 4 divided doses/day
Label: Gantrisin .5 Gm/tsp
Wt. = 40 lb
How many ml should be admnistered per dose?

24. Order: Codeine Sulfate g 1/2 po
Supply: Codeine Sulfate 15 mg/tablet
Give ________________ tab.

25. Order: Riopan 10 ml po
Supply: Riopan 400 mg/tsp
Give: _______________ mg

EXHIBIT L

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing-Technical Program

COURSE SYLLABUS

COURSE:	510-150 Intermediate Nursing		
CREDITS:	Section I	*Theory	2 credits
	Section II	Laboratory/Seminar	1 cr.

*challenge options available

PREREQUISITES: 510-101 Nursing Skills I
510-114 Nursing Skills II
510-110 Introduction to Nursing
All courses prerequisite to or concurrent with the above

LEAD INSTRUCTOR: Eleanor Walter

RESOURCES:

Textbooks:

Brunner and Suddarth, Textbook of Medical-Surgical Nursing, 6th Edition, Lippincott, 1988.

Kozier, Erb and Buffalino, Introduction to Nursing, Addison-Wesley, 1989.

Ladewig, London and Olds, Essentials of Maternal-Newborn Nursing, 2nd Edition, Addison-Wesley, 1990.

McFarland and McFarlane, Nursing Diagnosis and Intervention, C.V. Mosby, 1989.

References:

COURSE DESCRIPTION:

The goal of this course is to link introductory knowledge of nursing actions and skills to knowledge of nursing roles and responsibilities. Concepts introduced in the previous course, specifically, the person, health, and humane caring are expanded as students are introduced to systematic care planning which includes teaching-learning activities. Clients experiencing pregnancy/childbirth and surgery are studied as these concepts are developed. In addition, these concepts are used to promote student understanding of self. Students are encouraged to consider how they have evolved as unique individuals, how this has led to their desire to assume the privileged role of nurse, and what implications this desire has for their future responsibilities. Two essential characteristics of a nurse are stressed: the ability of the nurse to relate to the client therapeutically, and the ability of the nurse to think creatively yet critically in making sound judgments about client care.

Key Terms/Concepts & Descriptions:

Humane Caring: "Caring is the moral idea of nursing whereby the end is protection, enhancement, and preservation of human dignity." (Watson, J. 1988). Caring not only implies recognition of another's need for protection, enhancement, and preservation of their human dignity, but also the commitment to take action in meeting their need.

Therapeutics: Any and all interactions (physical, psychological, and spiritual) performed by a nurse to protect, enhance and preserve the total health of her/his clients.

Critical Thinking: The ability to recognize multiple factors affecting a situation, weigh them in relationship to each other and formulate judgments as to their combined impact upon the situation.

Creative Thinking: The ability to take what is analyzed by critical thinking, add new factors to it, and effect a greater degree of understanding or a better outcome, than what would otherwise have resulted.

COURSE OBJECTIVES;

Upon successful completion of this course, the student will be able to:

Knowledge base:

IIa. Explain the components of the nursing process and indicate how components interrelate to achieve resolution of client problem.
IIb. Identify how the components of the teaching/learning process establish and/or promote client competencies.
IIc. Identify the characteristics and benefits of effective therapeutic client care.
IId. Explain examples of client behaviors using Gordon's framework for understanding functional health patterns.
IIe. Explain how family and environmental factors influence the client's behaviors.
IIf. Identify desired characteristics of thought processes which assist the nurse in making safe, client-centered clinical decisions.
IIg. Identify and integrate facts, concepts, and principles regarding normal human conception; fetal development; birth; life stages and death into related nursing actions.
IIh. Identify and integrate facts, concepts, and principles regarding human responses to life stressors (surgical intervention, pain, expected and unexpected lifestyle adaptations) into related nursing actions.

Critical/Creative Thinking:

IIi. Describe the thought processes which they as an individual had in arriving at a conclusion or course of action.
IIj. Detect, analyze and address omissions and inaccuracies in the processes described in IIi.
IIk. Surmise as to how others arrived at a conclusion/belief.
IIl. Describe actions which one could take to provide information to someone who lacks it.

Humane Caring:

IIm. Select methods of expression and communication which match the unique client's interaction preference.

BEST COPY AVAILABLE

IIn. Speculate how they as individuals have come to possess experiences and consequent personalities which could affect their ability to function in a caring manner.

INSTRUCTION UNITS:

Seven units of combined theory and seminar, divided as follows:

I. Course Overview and Conceptual Framework: Where are we going on this journey into nursing as a discipline? What will help me organize everything I'll be learning?

II. History and Nursing Process: How has nursing evolved to its present form? What legal protections and mandates are there for nursing?

III. The Nurse/Client Relationship: awareness of self and others as unique individuals. What do I bring with me on this journey into my life's work? What do those I serve bring with them into their state of need? How do the two interact?

IV. Nursing's Care for Human Needs: How do I as a nurse express care to people at various phases in life? How do I promote a client's adaption to changes in role, self-image or to grief?

V. Quality of Nurse-Client Relationship: What is the nurse's role in helping to bring about improvement? How does a nurse assist client's in meeting physiological, psychosocial and spiritual needs? What does it mean to be therapeutic?

VI. Teaching/Learning: What is the nurse's role in bringing about improvement when the client's needs involve having to change?

VII. Creative/Critical Thinking in Action: Which nurse makes a difference?

****

As you look through this course syllabus, please notice several things. In the outline of the units, there are three sections. The first column gives the objectives: what it is that you should know, value, or do when the unit is complete. Accomplishing these objectives means you should also meet the course objectives described earlier. The second section is content. We have deliberately avoided a more typical outline approach to this. We have chosen to pose the content as questions. We intend for you as students to come with an inquisitive attitude and to realize that many times there aren't definite answers, but instead more questions. The questions are designed to guide your journey through the course. You may have questions of your own to add. We would encourage you to share these during class time. We also believe that developing the habit of asking questions--of seeking out knowledge--will be valuable to you throughout your career.

The third section describes the learning activities. Some of these are familiar activities: readings from textbooks and articles, small group work, media to view. There are some less familiar activities as well. The variety recognizes that we don't all learn the same way and so may need different types of activities.

METHODS OF INSTRUCTION:

Large group interaction in lecture and lab-seminar periods.

Within this context:

1. faculty/student modeling of thought and related role play
2. semester project and sharing of new insights into course concepts
3. structured experiences using small group discussion/large group enhancement
4. discussion of insights by faculty and students
5. exposure to peer enhancement
6. required class preparation (encouraging peer/significant other interaction) -honor system for monitoring
7. required self-introspection: structured reaction papers

Autotutorial materials:
- as preparations
- as aides for make-up
- as aides for difficult areas of individual students
- as class stage-setters.

Student participation in test preparation.

METHODS OF EVALUATING STUDENT'S PERFORMANCE:

Assessment of prior learning through challenge examinations with waiver of attendance requirement for specific content areas where challenge is met.

Written examinations
Faculty/Peer interaction
Student self-exploration
Verbal Articulation:
    in day-to-day class participation
    in one-time, individually prepared class presentation
Written Articulation:
    of a two-page concept paper (focus: purposeful exploration of ideas, resource use/citation; highly structured)
Faculty/Peer assessment

The course grade will be based on:

1. Six exams--may include multiple choice, short answer and essay questions
2. Class participation
3. Written paper
4. Class presentation: grades by faculty/peers.

A score of at least 78% of the points is required to pass the course.

POLICIES AND PROCEDURES

Policies:

All questions stimulate thought and therefore will be received and reacted to with respect. In the interest of class time however, the instructor may opt to postpone reaction until a later or non-class time. Students are expected to react in an equally respectful way to the questions/material posed by the instructor. This is demonstrated by a genuine effort to prepare for classes, assignments and projects.
All participants in this learning trip (faculty and students) are expected to weigh the reactions of others in helping to form and reform their own thoughts.

Attendance is expected and recorded at all class sessions. In accordance with Chippewa Valley Technical College policy, attendance records are reported to the Registrar. Frequent absences will result in referral to a counselor for follow-up.

JT/DP/12-89/bh
IN/CSyll.W90

UNIT I: CONCEPTUAL FRAMEWORK (And Away We Go!)

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
The student will:	This will be achieved through knowledge of:		They will gain/deepen/integrate such knowledge by:	
1. Have had an initial memorable group experience which links past experience with present course expectations. This will be demonstrated by their ability to formulate personally meaningful answers to the content questions outlined.	LEARNING'S TRAITS: What is most likely to be remembered/retained/used? What is "learning" for anyone? For you? Of what value are rules in learning? Of what value are tools in learning?	P	preparation of syllabus and other materials	participation
		E	conduct 2 hour class, small/large group discussion focused on content	risking sharing feelings doing assignments
	COURSE KEY CONCEPTS: Humane caring, therapeutics, critical thinking, creative thinking.	E	provide first directive for reaction paper	interaction
2. Be able to apply these concepts to their own use of the syllabus, text, instructors, and peers to help facilitate digestive learning of the course's key concepts and functional aspects.	COURSE DESIGN: Functional aspects, methods, evaluation; specific activities; student's role; faculty's role.	R	introduce art connection and enrichment through examples	following through
			answer/field questions	
	STRENGTH BUILDS ON STRENGTH: need for carryover of self-starting habits from Introduction to Nursing.		suggest alternate ways of exploring the concepts	
3. Be able to articulate thoughts regarding their own past self-perception as a learner, present perceived needs and how they hope to meet them.	MAIN CONCEPTS OF CONCEPTUAL FRAMEWORK: Person, Health, Nursing, Society. Interaction among these concepts.		provide structured activity suggestions on how to further explore	
			explain how method of student involvement in test construction helps solidify their learning, helps detect their own short falls and address them	(P E E R: learning through experience created while in relationship with others is more memorable, allows broader exposure, and thus is more likely to be individually relevant, leading to retention and use.)
4. Understand the conceptual framework for the program as the organizational key to their coursework.			Myers-Briggs or other inventory?	

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
5. Be able to identify how critical thinking and creative thinking complement each other.	DEFINITIONS: critical thinking, creative thinking, connecting thinking to the rules and process of learning. Noticing your own thinking and the thinking of others. Relating past practices to definitions. What are the foundations?	P	review some definitions of critical and creative thinking	seek other definitions
6. Recognize that critical thinking is an ability that can be developed and improved through guidance and practice.		E	form some linkages of critical and creative thinking to the process of learning	participate in presenting an issue from another point of view
7. Relate past and current thinking practices by:	What abilities and attitudes are useful for success in academic courses? Is there a map to guide me? How do I know when I'm thinking critically? How do I practice? What are the facts? What if I don't like change?	E	provide the first stage of a structured (map) approach to critical thinking	review map and reflect on ways to use or add to the map
			discuss the myth of the right answer	consider implications and consequences of one right answer
7.1 explaining the difference between passively absorbing information or actively asking questions about information.	What are the advantages of absorbing information provided by the experts? How comfortable am I with a relatively passive approach to learning? Is what I read last the most correct?	R	present examples of critical and creative thinking	
7.2 describing with examples some advantages and disadvantages of each approach.	How do I move from absorbing information to searching for the essential elements when reading? How do the two appraoches complement each other.			
7.3 recognizing when emotional involvement interferes with the reasoning process.				

UNIT II: NURSING'S EVOLUTION (Others Have Travelled on This Road to Create the Present)

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
1. Describe various historical influences and the systems for provision of care that have existed in nursing.	How has nursing gotten to be what it is today? What was nursing like 200-100-50-20 years ago? What is current nursing practice?	P	1. trivia quiz on historical highlights of nursing	1. read articles from old journals (20-50 years) or texts; Kozier Ch. 1-2. view Luther Hospital hall display of historical materials
2. Explain the legal requirements of Wisconsin's Nurse Practice Act.	Why is there a law governing Why is there a law governing nrusing practice? Whom does it protect? What could happen if there weren't laws which structure practice?	E	2. verbally walk students through Nurse Practice Act	2. read Nurse Practice Act, note prohibitions/mandates; compare to conceptual framework
		E	guide discussion	
		R	video "Whose Liability Is It? The Practice of Nursing and The Law"	REACTION PAPER: How could Nurse Practice Act be improved? Does it reflect present realities in nursing? Does it inhibit development of the profession? share reaction papers in small group
3. Identify, define and apply in simulated situations the steps of the nursing process using NANDA format and terms.	What do I need to know about a patient to provide safe and humane care?	P	design activity instructor led group discussion of content	familiarization with someone not known well; use six senses to gather data view video "Nursing Diagnosis, Planning and Intervention" readings: Kozier and Erb, Ch 7

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
3.1 Assessment and Nursing Diagnosis	How do nurses communicate what they know and do to other nurses? How do I know if this is all working? What happens when the best laid plans go awry?	E	feedback on all fronts	role playing interviews with video
a) identify how to thoroughly and accurately collect data about client's needs and strengths using multiple sources				Kozier, Ch. 8-9 review physical assessment skills on own in lab
b) interpret findings into Gordon's framework and language		E	Prepare list of interview questions to give to students. Students are to describe what type of information is likely to be obtained by each question.	REACTION PAPER: Is there ever a way to say a wrong thing or ask a wrong question? Small groups (possibly clinical) draft list of ways to ask difficult questions, brainstorm. Using case studies critique another group's work and decide what else you would need to know and how you'd find out.
c) conclude the steps in a logical nursing diagnosis using NANDA list and PES format		R		
3.2 Care Planning/ Intervention	How does it feel to have someone else think for you?	P	review unit objectives with students as example of outcome criteria; grades as measures of evaluation	Kozier, Ch. 10-11 learning module reflect on time when they needed a solution and got an excuse instead
a) list benefits of involving patient in planning care	Who's solution is the best? Who's solution is most likely to work? What do you mean, "would we like to take a bath?" Chicken or egg? Can something work if you don't believe it will?	E	review how to write a definitive outcome criteria, present unusual care plans, explore creative ways to evaluate	case studies, computer simulations Kozier, Ch. 12
b) establish outcome criteria which: are stated in terms of client behaviors focus on elimination of problem describe measureable change	How much is enough? Why? Why? Why? Who said it? What does it mean?	E R	give sample care plans without outcome criteria, formulate so as to set up ease of evaluation; re-address by revision of interventions	learning tree write outcome criteria and exchange for critique

Unit Objectives	Content	Faculty Cue	Self/Peer Cue
c) develop nursing interventions to help client eliminate the etiology and to assess the progress toward the outcome criteria: state rationale for nursing intervention document source of rationale		give examples of well and poorly written outcome criteria	identify poor criteria and suggest improvement
3.3 Evaluation	What happened? So where do we go from here?		
a) establish realization that nursing process is continuous			
b) adjust care plan to reflect new data, non-achievement of outcome criteria, or a problem not resolved			

UNIT III: NURSING'S CARE FOR HUMAN NEEDS THROUGH THE LIFE SPAN
(Everyone is on a Path. Where does Nursing's Path Cross a Client's Path?

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
1. Minds forming bodies		P		Review anatomy and physiology of reproduction.
1.1 Identify factors affecting fertility; describe factors influencing decision to conceive a child.	Why do people choose to reproduce? What are the emotional and physical risks in choosing to reproduce? How are identity and intimacy related to this decision? What does our society say about reproduction? Do men and women perceive this differently? What happens when there is no desire, yet pregnancy results? What happens when there is desire and no results?	E E R	quiz on attitudes, myths, social expectations of child-bearing and parenting use students' experiences (from preparing in sharing group) to categorize nature of concerns/feelings: personal--self-fulfillment social--parental/peer pressure physiologic--biological clock intimacy--desire to procreate with partner financial	Ladewig, Ch. 2 and 4 Review developmental psychology for related content on identity and sexuality, parenting roles. Kozier Ch. 14-15 If have children, think about what influenced decision or ask parents about own conception/birth. Ladewig, Ch. 8 Share insights in small group. Attend a meeting of RESOLVE THROUGH SHARING at Luther or other similar support group at Sacred Heart.
1.2 Identify factors influencing parenting; describe the phases of emotional adjustment parents experience during pregnancy. Discuss the developmental tasks of becoming a parent.	Once a child is conceived, can the conceivers do justice to the new life? How do I know I'm really pregnant? How does pregnancy affect the parents? What impact is there on self-image, sexuality, intimacy, roles? What are helpful/caring behaviors for the parents-to-be during this time?	P E E R	1 period: panel presentation with 3 women/couples at various stages of pregnancy to discuss thoughts/attitudes. Using comments from panel, identify developmental tasks, role changes, adaptations in self-concept,	Ladewig, Ch. 6; video film "Story of Eric" (MED 67) PARTICIPATE BY DEVELOPING QUESTIONS IN ADVANCE.

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
Discuss the significant events to the mom of each trimester of pregnancy.	What are the usual problems to anticipate during this time?		intimacy, body image during each trimester	Determine effectiveness of questions; revise
2. A body within and and from a body 2.1 Fetal Development/ Physical Adaptation to Pregnancy:	What changes does the woman experience in her body? What can she expect in these nine months? As a beginning person, how do I grow? What dangers are there in my first nine months? How can my mom take good care of me?	P	Arrange list of significant events in fetal development for students to place in chronological sequence.	Review A & P text regarding fetal development; also Ladewig, Ch. 5. Videos: "Born Hooked" (MED 75), "Alcohol Crisis" (MED 76), "Women Child" (MED 77), "Miracle of Life" (3/4)
a) Describe in sequence the landmarks of fetal development.		E	Review concepts of: teratogens, susceptibility, critical periods, placental barrier	Ladewig, Ch 7, 9, 10, 11, 12, 13
b) Recognize the hazards to the fetus.		E		Small groups: devise plan of what prenatal parents should know to promote best conditions for fetus.
c) Recognize risks to mother.		R		Exchange plans with another group, or as whole class, compare plans and rationale. Clarify/ make additions.
2.2 Labor and Delivery: a) Identify the characteristics of each stage of labor.	Look out world, ready or not, here I come! How do I get out of here? What does mom experience as the baby is born? How long does it take? How long does mom's state of health, emotions, position affect the process?	P	Role play couple in labor (nurse functions in non-caring way)	Ladewig, Ch. 14, 15, 16, 18, 19
		E	Re-do role play.	After observing role-play, suggest therapeutic caring interventions based on patient's behaviors and on brief announcements of physiologic changes (e.g. dilation, pulse, BP, FHT); should also include awareness of environment.
b) Describe the adaptations of the mom and baby during the birth process.		E		
c) Describe ways to show support and caring to the birthing family.		R	Follow-up in clinical course.	

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
2.3 Involution and Adaptation to Extra-uterine life:	How does the mom's body respond to the end of pregnancy? How does the newborn's body respond to life outside the womb?	P	Resource to small groups, moderate large groups	Videos: "Newborn Assessment" 5 point check Ladewig Ch. 20, 21, 22, 25, 26
a) Describe normal process of involution, specifically first 48 hours.		E		In small groups, each group consider one or two of Gordon's categories, list and describe both mom's and babe's post-partum adaptation. Suggest essential nursing interventions. Share with whole class in written form to be used as clinical tool.
b) Describe neonatal adaptation required for survival in first minutes, hours, days of life using Gordon's functional categories.		E		
c) Describe nursing actions to promote and maintain involution and neonatal adaptation.		R		
2.4 Physical and Emotional Adaptation of the Altered Family:	What happens when things go right? What happens when things go wrong? Is what seems right/wrong to us what seems right/wrong to the family? How does nursing action rise to each occasion?	P	View "Baby Basics" as an example of material to cover on Post Partum Unit.	View "Baby Basics" as an example of material to cover on Post Partum Unit.
a) Describe anticipated changes (learning) new parents will need to accomplish.		E	Using prep thoughts, in large group, identify common trends/traits which result when there is either dynamic. How do they differ? Consider elements present when there has been successful resolution, when there hasn't been. Consider role	Consider a time where you have strongly disagreed with someone close to you and a time where you have been mutually dissatisfied over a "family" matter. Reflect on feelings and identify.
b) Describe circumstances where the altered family state is not optimal.		E		

c) Describe how nursing is involved in this learning within the context of performing 2.3(c) above.		R	outsiders have played in resolution: help/hindrance. How is nursing role like/ unlike an outsider.	REACTION PAPER: Consider personal tendencies and ability to function as nurse in situations where there is disagreement or dissatisfaction.
3. Bodies and Minds Living in Relationship	How does a family change over the years? What struggles can parents expect? What makes for a successful family?	P	Present brief case study of middle aged couple with children and elderly parent to care for. Students use Holmes and Rahe's Stress Index to determine stress level on parents.	Review Mid-life from Developmental Psych readings. REACTION PAPER: on Duvall's Theory in their lives.
List in order and describe Duvall's stages of family developmental tasks.	What is it like to be a member of the "sandwich" generation?	E		Compile list of community resources for "sandwich" age group.
Identify two developmental tasks for each stage.	Does our culture/society care for the caretakers? Do extended families still exist? How does the elderly person fit into today's family structure?	E	Guide discussion on role changes, intimacy, support systems, parenting. Use Duvall's stages, developmental tasks, stress scale to help students develop understanding of this age group.	Kozier, Ch. 28 and 30
Understand the stresses imposed on families with two generations of dependents.		R	Guide discussion from reaction papers to consider family development/helps hindrances to accomplishment of developmental tasks.	
Discuss factors in the family and environment that place individuals and families at risk for physical or emotional problems.	How does physiologic aging affect a person's view of the world and consequently their ability/willingness to perform? What do elderly people want from their adult children? What does institutionalization do to a a person? How are the ill effects made worse for an elder?			Review Developmental Psych
		P	Sensory impairment experiences	Kozier, Ch. 21
		E	Using video as a case study, identify hazards and helps for the elderly person. Also review grief/loss and its implication regarding independence ego integrity.	View: "Peege to Hell with Grandma" Kozier, Ch. 29

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
		E	Aging Game	
		R	Discussion on appropriate nursing interventions and attitudes to assist elderly in maintaining health.	
			Introduce physical assessment of age-related changes.	Conduct on friend/relative Compare assessment findings in group.
4. Effects of maturing on bodies and minds: what happens when bodies need fixing? 4.1 Describe the responsibilities of the perioperative nurse for care of the client, informed consent and asepsis.	What does a surgical nurse do? How do I know if informed consent is really informed? Who takes care of the client's family?	P	Invite guest speakers: RN from surgical unit, RN from surgery, RN from PAR, RN from a surgery center. Send them agenda of topics to cover.	Reading assignment Ask questions of panel. Write reaction to speakers including: a) responsibilities identified b) legal parameters c) differences in setting
	How does the setting affect the role of the nurse? What are the different responsibilities?	E		
4.2 Compare and contrast the roles of the perioperative nurse in ambulatory care and the hospital setting. 4.3 Identify the necessary perioperative assessments the nurse must make.	What do I need to know about a client before surgery? Where and how do I find out? How much responsibility does the nurse have for the client during surgery? What do I watch for after surgery? How do I know when a client is headed for trouble?	E	Acquire sample checklists from several places. Make into overhead transparencies.	Notice similarities and differences between check lists. Discuss the rationale for the items included. Reading assignment
		R		

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
4.4 Describe the anticipated needs of the client perioperatively using Gordon's categories and NANDA.	What do clients undergoing surgery usually think and feel? How does the body react to this invasive procedure? What do clients want to know but are afraid to ask about the procedure, diet, activity, recovery? What possibilities exist to help the client after discharge? What do I say to someone who is afraid of dying during surgery?	P	Prepare and act out role play of preoperative admission interview, emphasizing psychosocial and spiritual aspects.	Critique role play: What did nurse do well? What else could she do? Develop nursing diagnoses based on role play.
		E	Develop guide for interview to help students focus on desired points.	Interview someone who had surgery within past year. Bring comments to class.
		E	Resource person to small groups	In small groups, working from interview notes, develop a composit list of pre- and post-op needs of clients, group by Gordon's categories, write possible nursing diagnoses.
4.5 Describe pain management approaches both nonpharmacologic and pharmacologic.	What if my client can't stand needles? How does age affect the perception and expression of pain? Does patient controlled analgesia work better than traditional methods? Is it safe?	R		
4.6 Discuss factors that influence the client's response to surgery.	What things make surgery risky for a client? Do children respond differently than adults? Does what is said during surgery influence a person's recovery? Why are the surgical risks greater for an elderly person? What about type of anesthesia or anxiety or the client's expectations, how do those affect surgical outcome?	P	Develop bibliography of articles that discuss surgical risk factors.	Read assigned article and prepare two-minute summary to share with class.
		E	Discussion in class of physiology and development underlying the risk factors.	

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
4.7 Identify nursing interventions to promote healing and to prevent or alleviate complications.	What can I do as a nurse to help a person get back to his usual level of functioning? How important postoperatively is emotional care? What needs to happen for a person to go home safely?	P		Reading assignment Review support services from rotation to surgical settings.

UNIT IV: QUALITY OF NURSE/CLIENT RELATIONSHIP (My Path)

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
Identify those personal characteristics/values which have led them to desire being a nurse.	What does it take, personally, to be a nurse? Do I have what it takes?	P	Provide structured pre-class self-assessment tool.	Do self-assessment tool in advance with significant other.
Speculate as to factors which have established these.	Just why do I want to be a nurse? Who or what has influenced this desire?	E	Four one-hour sessions spaced over semester, focus: drafting/redrafting sharing regarding their personal definition. Final session: evaluate semester development.	Continue to follow up with significant other as to progress.
Speculate as to how others may have developed different characteristics and values.	What do others see as important in a nurse? What experiences have led them to value these characteristics?	E	Comment in Reaction Paper (based on clinical experience) as to positive or negative success in meeting the concepts identified in their definitions.	Review Kozier, Ch. 1
Use these thoughts to formulate ways of approaching clients while doing psychosocial assessment.	What do I believe about what nursing is and what a nurse does and how a nurse relates to clients?			
Formulate a personal definition of nursing which: a) provides an initial basis of operation as a student. b) accounts for the way in which the student will relate to the client as a unique individual. c) allows for redefinition as professional growth takes place.				

UNIT V: QUALITY OF NURSING ACTION (How to Not Miss the Intersections)

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
1. Understand that caring without action accomplishes nothing.	1. How do I let patients know that I care about them? Am I legally required to act on everything I know about a person? What about ethics? How much control should a patient have?	P	Prepare and read through 3 or 4 "what would you do if" situations for students reactions in class. Emphasize need for both care and action.	Review Nurse Practice Act, especially issues of confidentiality. Kozier, Ch. 5 and 6
2. Define the focus and dual nature of "therapeutics" as used in this course. 3. Recognize caring as a critical function of nursing, expressed through physical acts and interactions.	2. and 3. What does it really take to be therapeutic? Does how I provide physical care affect a client's emotional and spiritual well-being? How do I satisfy emotional and physical needs when I barely have time to provide physical care and do my charting? How do patients describe an excellent nurse? What about other nurses; what do they see as a caring, competent nurse? other nurses; what do they see as a caring, competent nurse?	E	Guest speaker: a nurse/ lawyer or a person with experience in malpractice/ negligence issues.	Articles on 1) malpractice and its prevention, usual causes 2) research articles on patients' perceptions of nursing care 3) articles on caring, meeting emotional and spiritual needs
		E	Guide discussion on students' experiences: in role as student, in work setting, or even as a patient. What demonstrated caring? What did not?	Summarize one experience which demonstrated caring in the fullest sense, or else a lack of caring. Point out how you arrived at your impression.
		R	Clinical Practice	
4. Describe situations and/or topics in which the nurse should initiate a caring relationship.	4. What should I do, if anything, when a client finds it hard to talk about something? How can I best demonstrate caring at these times? What are the areas most people have trouble discussing? How do I get over my own reluctance to talk about certain topics. What areas are hard for me?	P	Prepare rank order listing of topics hard to talk about.	Complete rank-ordering activity. If possible, jot down why a certain area is difficult for you.
		E	Share compiled rank orders for groups. Discuss possible variations based on cultural background, age, sex. Discuss personal and social "taboos".	Kozier Ch. 20

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
		E	Role-play situations--interviews, assessments, counseling or teaching--based on the most common difficult areas.	
		R		Jot down several new ways to intervene that you learned in this unit. Write a plan for yourself on how to overcome your hesitancy to deal with certain topics.
5. Identify possible consequences when a nurse betrays a client's confidence and trust.	5. How important is the client's trust and confidence in me? How does my failure to maintain that trust affect the client? What consequences might I face legally, ethically, and in my career?	P		Readings: lawsuits filed against nurses for betrayal of trust. Write down the consequences for the nurse and for the client.
		E		Video depicting nurse/patient relationship and maintaining trust, "Sounds of Anger, Echoes of Fear", or "Clarifying Relationships".
		E	Guide discussion of vignettes in video(s) emphasizing consequences of actions.	
		R		

UNIT VI: ROADBLOCKS AND BRIDGES OF LEARNING

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
Identify characteristics of change.	Is change good or bad? Is stress good or bad?	P	Give direction on ITEM preparation: traits of others who have influenced personal learning.	prepare with others (classmate/family)
Link understanding of change concepts to learning theory.	What exactly is a balanced life?			
	What is a surprise? How is imagination helpful? How are others involved?	E	Direct linkage of identified traits (above) to self-assessment strength/weakness.	self-assess
Identify factors which necessitate change/learning in life/health experiences--expected and unexpected.	What is adaptation?			
	What are differing views as to the definition/principles of learning?		Identify theoretical components of teaching learning phenomenon.	connect to personal experience
Identify common human responses to change.	What are your views as to the definition of learning?		Link both to concepts of teaching/learning--further link to usefulness of T/L format (a means which prompts concepts to effective practice).	VIA OWN EXPERIENCE identify facilitative and non-facilitative T/L situations. Identify factors affecting both. Identify creative ways for nurses to teach.
Identify how the varying personalities of individual selves may result in varying interpretations of what is good or bad about change.	What do you see as your nursing role/responsibility for client teaching?			
Identify how different interpretations will result in different reactions.	How do you plan to become competent at accomplishing this?	E	Structure use of this information so student can perform task.	
	Who is ultimately responsible for change?	R	Identify continued program expectation of them as "teachers".	Consider how depth of teaching ability will increase through the program and into practice.
Identify how the nurse/teacher fulfills a role of advocacy in accomplishing change (learning) with the client/self.				

UNIT VII: PUTTING IT ALL TOGETHER (The Nurse as a traveler - who makes a difference?)

Unit Objectives	Content		Faculty Cue	Self/Peer Cue
1. Be able to describe with examples the common tendency to think: 1.1 in a narrow self-serving way 1.2 as others think.	Did some restructuring of perceptions and behaviors occur this past semester? Why? Why not? How to avoid the pitfalls of thinking in a narrow self-serving way? Appreciating other points of view without buying into thinking as others think.	P	stimulate discussion by citing several examples of egocentric thinking, sociocentric thinking, critical thinking	document and share one example of each: egocentric thinking, sociocentric thinking, appreciating other viewpoints
2. Describe thier own thought processes including how omissions and inaccuracies could or did occur in the process of arriving at a course of action.		E	review definitions; clarify and give feedback	avoid oversimplification
	What influenced me most when I charted a course of action? Did I really look for omissions and inaccuracies in my thinking?	E	form linkages from introduction of the questioning format to the desired outcome of the course	
3. Describe at least two situations that occurred this past semester in which the recognition of multiple factors made an impact on the outcome of the situation. 4. Illustrate with an example: 4.1 how asking questions has affected a personal decision about the worth of something you read this semester. 4.2 how a nurse can make a difference when actions are based on critical and creative thinking.	Reflecting: What have I learned? How was it useful to me, to others? How do I work at understanding the viewpoints of others? How did the question asking approach work for me, for others? How did it influence my ability to make decisions? Solve problems? Did it help me to know what to accept? What to reject? When to withhold judgment? Does critical and creative thinking make a difference? Why? Why not?	R	recognize behaviors that reflect critical and creative thinking detect and address alternate approaches	share reflections and views evaluate successes and shortcomings

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
Case Studies

Case 1:

You have a G1 P1, 26-year-old woman who is 48 hours post delivery. You are told she is experiencing no complications. You are to go in and do a final postpartum assessment. What would you include in the assessment and what parameters would you expect to find for each of your assessments. Give reasons for your anticipated findings.

Case 2

Robin is a 16-year-old unmarried teen who lives with her mother and stepfather. At 35 weeks she delivered a baby boy who was diagnosed as SGA and experienced some transitory respiratory distress. Robin was discharged 48 hours after delivery while her baby remained in NICU. Robin had not called or visited on subsequent 2 days. The staff nurse calls Robin at home to assess postpartum adjustment at home. What kinds of questions might the nurse ask during the assessment?

Case 3

Sara Brown (G1 P1) is a married, 32-year-old who has had a 3799 gm baby girl via vaginal delivery with episiotomy. During her 2-day postpartum stay in the hospital she had some questions about self-care and baby care which were discussed with the nurse. She is breast feeding and has some anxieties about this. The clinic nurse calls Mrs. Brown a few weeks after her discharge from the hospital to follow up on her postpartum adjustment at home. Mrs. Brown states she feels the baby is not getting enough milk because she is cranky. She also states she is very tired and has breast discomfort. What other question might the nurse ask during this assessment.

Case 4

Mrs. Lee Song (G 4 Para 4), a 28-year-old Laotian woman, has delivered a 4.76 Kg baby 3 hours ago. Your assessment results in the following information: V.S.: R22, P86, T37.6° C, B/P 122/78, fundus palpated to the left of the midline slightly higher than midway between the umbilicus and symphysis. Lochia discharge is bright red and one pad has been saturated in the last 1 1/2 hours. Perineum is edematous with some ecchymosis. Hemorrhoids are noted. Mom tells you she is very tired and would like a snack. What further assessment would you make? What is your assessment of Mrs. Song's status? What nursing care would you initiate and why? Document what you noted and what you might note on the remainder of the assessment.

EW/2-90/bh
IN/4CStudy.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
Panel Participants - Adjusting to Pregnancy

How have your feelings about yourself changed during your pregnancy?

Have your activities changed during the pregnancy?

What do you like/dislike about being pregnant?

What thoughts or feelings do you have about your baby?

What changes have you noticed in your spouse during the pregnancy? Has your relationship changed during the pregnancy?

What do others do that is either helpful or not helpful to you at this point in your pregnancy?

DP/1-90/bh
IN/AdjPreg.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
Pain Forum
Spring, 1990

Objectives:

At the conclusion of this laboratory experience the student will be able to:

1 describe differences between acute and chronic pain.
2. describe pharmacological methods of pain management.
3. describe noninvasive (nonpharmacological) methods of pain management.
4. describe pain management in special client populations.

Learning Activities:

1. Students will form groups with four to five members each.
2. Each group will sign up for one of the topics listed below.
3. Each group will prepare a report to be presented in panel discussion format. (Each group will be allotted approximately 15 minutes for its report and discussion.) The report should be based on reading from texts as well as current nursing journal articles, and interviews with health care workers who deal with pain management.
4. Each group will submit a bibliography as well as a listing of health care workers interviewed.

Topics:

1. Characteristics and management of acute vs. chronic pain
2. Common pharmacological agents used in pain management
3. Noninvasive pain management techniques, for example: TENS, other cutaneous stimulation, relaxation, biofeedback, imagery, hypnosis, etc.
4. Pain management in special client populations, for example: obstetrics, oncology, rheumatology, acute postoperative, minority cultures, pediatrics, etc. (Choose one population; this topic will be used by more than one group but the population discussed may not be repeated.)

RA/9-88Rev8-89/bh
NPII/PainForum

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
SIGN-UP SHEET FOR PAIN FORUM

Topic	Group Members
1. Characteristics and management of acute vs. chronic pain	1. 2. 3. 4. 5.
2. Common pharmacologic agents used in pain management	1. 2. 3. 4. 5.
3. Noninvasive pain management techniques; for example: TENS, relaxation, biofeedback, imagery, hypnosis, acupuncture	1. 2. 3. 4. 5.
4. Pain management in special client populations Population: ________________	1. 2. 3. 4. 5.
Population: ________________	1. 2. 3. 4. 5.
Population: ________________	1. 2. 3. 4. 5.

DP/2-90/bh
IN/PainForu.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
Anonymous Survey: The Decision to Have a Child

What kinds of messages does our society give to women about having children? Think about relatives, friends, commercials. Do factors like age or marital status affect the type of message?

What about messages to men? How are they similar or different?

If you have children, write down how you decided to have the child at that time. If you have more than one child, were there differences in how you made each decision? If you do not have children, talk to a friend or to your parents about this.

DP/1-90/bh
IN/Survey.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
I.T.E.M. #3
Wisconsin's Nurse Practice Act

As a nurse, you will need to know the legal requirements and limits of your work. In Wisconsin, Chapter 441 of state laws, also called the Nurse Practice Act, defines nursing practice. Read your copy of Chapter 441 and also read pages 82-83 of Kozier, Erb, and Buffalino. Then respond to these questions.

1. There are different sections of Chapter 441, numbered as 441.01, 441.04, 441.05, etc. To get an overview of this law, write down the topic of each of these subsections.

2. What are the duties and responsibilities of the Board of Nursing?

3. Is Wisconsin's Nurse Practice Act mandatory or permissive? Which section of this statue defines this?

4. Look at sections 441.11(3) and 441.11(4). How is the practice of practical nursing differentiated from that of professional nursing?

5. What does Chapter 441 require you as a nurse to do? What does it prohibit?

6. Now for some personal reflection. Did anything about this law surprise you, either by its inclusion or my its omission? Is the definition of nursing in Chapter 441 similar to your own? What else might you include?

DP/1-90/bh
IN/Item3.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING

Item #4

WHY AM I HERE?

We all have been exposed to many images of nurses through TV shows, books, movies, personal experiences and nurses we know. From these, we form an idea of what an ideal nurse should be or not be. You started on this path to a nursing career with an idea already in mind of the kind of nurse you would like to be. This ITEM asks you to focus on this image and on how your own personal characteristics fit with this image.

First write down your ideas about what a perfect nurse would be like.

Now take a look at the two sets of words on the next page. Using one set, mark one circle for each pair that would show which term best describes you. For example, the first pair is thoughtless-tactful. If you think you are very tactful, fill in Circle 7. If you are very thoughtless, mark circle 1. If you are usually tactful, but sometimes thoughtless, mark 4 or 5. Then turn the paper over so your choices are covered. Ask someone who knows you well to mark the second set, circling the words he or she thinks describe you. Spend some time talking about the similarities and differences in your choices.

Another aspect of knowing who we are as nurses is realizing what influenced our decisions to become nurses. Even if you are one of those people who says "I've always wanted to be a nurse", think some more about that. Why? Was it someone you knew who was a nurse? As a child did you like the uniform? Have you always liked taking care of others--did you bandage your teddy bears? Maybe you made your decision to be a nurse more recently. Again, what influenced you? Write down how you came to be here--describe people, events, thoughts that influenced and motivated you.

Finally, think about why you believe nursing is a first-rate career. Imagine that a friend of yours is thinking about becoming a nurse. She talks to you about it. What three things would you tell her to convince her that nursing is a good choice? Write them down here.

DP/1-90/bh
IN/Item4.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
ITEM #5

Teenage pregnancy is generally recognized as one of the most pressing social problems in our country. Many people have strong opinions about this area, especially about how to reduce the number of pregnancies in teens. This ITEM requires you to state your own opinion, then read several articles with divergent viewpoints and critique them, and finally, to re-examine your own opinion. None of this material represents an official position of Chippewa Valley Technical College or the Nursing Division.

FIRST: Describe what you believe about the causes of adolescent pregnancy. Why does it happen so frequently and continue to increase? What is the best way to deal with the problem? Who should pay the costs involved in addressing the problem?

NEXT: Read through all of the attached materials. Notice how the problem is defined, how statistics are used, and the source of each article. You will find it helpful to jot down key points as you go along or to summarize the main ideas of each article.

Now that you've read the articles, think about your reaction to them. Did any of them evoke a strong positive or negative response? Why? What methods did the authors use to support their opinions (things like referring to experts or statistics, choice of words, pointing out fallacies, omissions or distortions in the opposing viewpoint? Which of the viewpoints can you accept as valid?

Intermediate Nursing
ITEM #5

FINALLY: In light of all you have read, would you change any of your initial opinion? How, and what persuaded you?

DP/2-90/bh
IN/Item5.W90

EXHIBIT M

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

COURSE SYLLABUS

COURSE: 510-151 Intermediate Nursing Practice I

CREDITS: 108 hours

PREREQUISITES: All first semester courses and concurrent with
510-150 Intermediate Nursing Theory
510-115 Nutrition for Nursing Practice
510-130 Pharmacology
510-122 Pathophysiology I

LEAD INSTRUCTOR: Judy Speckhart

RESOURCES:

Textbooks: Textbooks from past and current courses will be used to support clinical learning experiences. The primary textbooks include:

Brunner and Suddarth, Textbook of Medical-Surgical Nursing, 6th Edition, Lippincott, 1988.

Fischbach, A Manual of Laboratory Diagnostic Tests, 3rd Edition, Lippincott, 1988.

Ladewig, London, and Olds, Essentials of Maternal-Newborn Nursing, 2nd Edition, Addison-Wesley, 1990.

McFarland and McFarlane, Nursing Diagnosis and Intervention, C.V. Mosby, 1989.

Shlafer and Marieb, The Nurse, Pharmacology, and Drug Therapy, Addison-Wesley, 1989.

References: Current nursing and other professional journals.

COURSE DESCRIPTION:

This course is taught concurrently with "Intermediate Nursing" (theory). A goal of this course is to promote student application of knowledge from the basic sciences and nursing theory courses to clients across the life span within the clinical environment. The course focuses on the development and implementation of nursing care plans and teaching-learning plans. The student will begin to use and analyze therapeutic communication skills. The course further invites the students to begin to develop a vision of "self" as a member of the discipline of nursing. Opportunities to develop sound decision-making abilities and communication of caring attitudes are promoted in the delivery of nursing care to clients and their families.

PERFORMANCE COMPETENCY:

Upon successful completion of this course, the student will:

1.00 Demonstrate caring behaviors, critical thinking, and utilization of the nursing process in providing nursing care to individuals and their families.

2.00 Utilize the teaching-learning process when providing care to assigned clients.

3.00 Identifies and utilizes appropriate resources for the provision of nursing care.

4.00 Assume responsibility for participation as a member of the health care team.

5.00 Use rational thinking strategies to obtain information relevant to client care.

INSTRUCTION:

Each student will be scheduled for a total of 12 weeks of clinical practice (4 weeks birth center/support services and 8 weeks perioperative settings). An introduction to each rotation will include campus lab discussions and clinical setting orientation.

Methods of Instruction

Preconference discussions
Postconference discussions
Individual student conferences
Supervised clinical laboratories
Campus lab discussions
Computer assisted instruction
Audiovisuals

Methods of Evaluation

Evaluation of clinical competency
Written requirements including:
  4 Nursing Care Plans (at least one must be for a Birth Center client)
  2 Process Recordings
  1 Teaching-Learning Plan
  Observational Papers including:
    Intraoperative and Ambulatory Care Settings

GRADING:

Course grade is derived from the following clinical rotations:
Birth Center/Support Services Clinical Performance. . . . 35%
Perioperative Clinical Performance. 65%

The course grade is determined by instructor's evaluation of the student's clinical performance using a point system on evaluation forms which are derived from course objectives. The student must have a passing grade in each clinical rotation in order to pass the course. The lowest acceptable passing grade is a "C" (78%). (See attached Clinical Evaluation Form.)

POLICIES AND PROCEDURES:

The students are expected to prepare prior to coming to clinical. If any student is unprepared to provide SAFE nursing care, the instructor may dismiss the student from clinical and require the student to meet with the program supervisor prior to returning to the clinical setting.

Clinical Attendance:

Clinical attendance is extremely important. Excessive clinical absence will make it impossible to meet the course objectives. If excessive absences occur, the clinical instructor will not be able to validate safe practice in intermediate nursing skills.

Therefore, the student may receive a failing grade for clinical. More than one or two absences are considered excessive for this course. (Remember, there is a good possibility of bad driving conditions, so use good judgment regarding attendance.) Absences are recorded and reported to Student Services where they are recorded on the student's record. Students with excessive absences are referred to a Student Services counselor. Students are expected to formulate a plan to correct the behavior.

Nursing Skills:

The student must have successfully completed each nursing skill in campus lab before the student may perform that skill in the clinical setting.

Reporting Absence:

CLINICAL LABORATORY:

1. Call Nursing unit.
2. Identify yourself, your instructor and leave a message regarding your absence.

CAMPUS LAB/SUPPORT SERVICES:

1. Call (715) 833-6417.
2. Identify yourself and give the information regarding your absence, including the instructor's name(s) in each class for which you will be absent.

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SCORING DESCRIPTORS

OUTSTANDING: Consistently superior in clinical performance, skill, synthesis of learning and application of nursing principles. Functions above expectations of student at this level.

1. Consistently functions safely and effectively with minimal guidance.
2. Demonstrates superior ability to analyze and synthesize information.
3. Demonstrates sound clinical judgement.
4. Seeks out and assumes responsibility beyond that required.

SATISFACTORY: Safe clinical performance demonstrates expected skills, synthesis of learning and application of nursing principles at expected level.

1. Consistently functions safely and effectively with occasional guidance.
2. Demonstrates ability to analyze and synthesize information with occasional guidance.
3. Makes appropriate clinical judgements with guidance.
4. Recognizes own limitations and seeks appropriate assistance.

MINIMAL: Clinical performance: is safe, background knowledge is deficient. Inconsistent safe clinical performance; demonstrates expected skills, synthesis of learning, and application of nursing principles at expected level with direct supervision.

1. Functions safely and effectively with frequent supervision.
2. Analyzes and synthesizes information with much guidance.
3. Accepts own limitations with guidance and uses resources as directed.
4. Accepts clinical judgements of staff and instructor.

UNSATISFACTORY: Clinical performance inadequate; indicates lack of skill, unsafe nursing practice, inadequate depth of knowledge, or application of nursing principles. Functions below expectations of student at this level.

1. Unable to function safely and effectively without constant supervision.
2. Unable to analyze and synthesize information with guidance.
3. Unable to make appropriate clinical judgements.
4. Does not accept responsibility for own actions.

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN

CLINICAL

COURSE: INTERMEDIATE NURSING PRACTICE I

Scale Points	O (4)	S (3)	M (2)	U (1)	Supportive Statements
Caregiver 1.00 Demonstrates caring behaviors, critical thinking and utilization of the nursing process in providing nursing care to individuals and their families					
1.01 Assessment *A. Completes holistic data base using Gordon's Patterns B. Analyzes the data using standards					
1.02 Nursing Diagnosis A. Writes nursing diagnoses using PES^ format B. Prepares list of actual and potential nursing diagnoses that are validated by the data base					
1.03 Priority Setting A. Prioritizes nursing diagnoses using a standard, eg. Maslow's Hierarchy of Needs					
1.04 Plan A. Develops individualized care plans for assigned clients B. Writes measurable outcome criteria that are relevant to the nursing care plans C. Selects nursing interventions that are based on scientific rationale and derived from etiology of the nursing diagnosis D. Documents resources used to support the scientific rationale for interventions					
1.05 Interventions - Dependent A. Applies knowledge of medications in caring for clients *B Implements treatments safely and effectively					
1.06 Interventions - Independent A. Establishes helping-trust relationships with assigned clients and their families B. Initiates caring behaviors with assigned clients and their families *C. Safely intervenes to promote, maintain and restore client's health status D. Documents interventions using designated format i.e., DAR, SOAP, narratives					
1.07 Evaluation A. Collects data specific to the established outcome criteria B. Compares data to outcome criteria C. Judges whether outcome criteria were met, not met or partially met D. Revises nursing care plan based on evaluation results					
Subtotal					

*Critical Indicators
^Problem Etiology Symptomatology

JS/11-89/bh
IN/ClinEval.Frm

EVALUATION ☐ INSTRUCTOR ☐ STUDENT

DATE: ____________________

Scale Points	O (4)	S (3)	M (2)	U (1)	Supportive Statements
Teacher 2.00 Utilizes the teaching-learning process when providing care to assigned clients					
2.01 Assesses the client and family for learning needs					
2.02 Identifies barriers to learning					
2.03 Assesses learner readiness					
2.04 Develops a teaching plan to meet the learning needs of a client and family					
2.05 Implements a teaching plan					
2.06 Evaluates effectiveness of teaching plan					
Subtotal					
Manager 3.00 Identifies and utilizes human resources for the provision of nursing care					
3.01 Organizes time to provide care efficiently					
3.02 Schedules nursing care to reflect priority of client health care needs					
3.03 Uses proper channels of communication to maintain flow of information and ideas.					
Subtotal					
Member of Discipline 4.00 Assumes responsibility for participation as a member of the health care team					
*4.01 Applies ethical and legal standards, ie. A. Uses ANA Nursing Standards of Practice B. Complies with Code of Ethics C. Maintains Confidentiality D. Legally documents client care					
4.02 Complies with school and agency policies, ie., dress code, punctuality, follows channels of communication					
4.03 Demonstrates personal and professional accountability A. Assesses own strengths and limitations B. Assumes responsibility for own actions C. Assumes responsibility for learning					
*4.04 Protects health of self and members of health team while implementing client care, i.e., universal secretion precautions					
4.05 Critically evaluates own experiences in initiating specific caring behaviors with clients					
Subtotal					
Investigator 5.00 Uses rational thinking strategies to obtain information relevant to client care					
5.01 Exhibits intellectual curiosity					
5.02 Demostrates characteristics of fairmindedness					
5.03 Actively seeks imaginative solutions to problems					
5.04 Identifies written resources relevant to client care					
Subtotal					
TOTAL SCORE					

Instructor's Signature ____________________

Student's Signature ____________________

DIRECTIONS FOR DETERMINING CLINICAL GRADES

1. Mark level of student performance for each objective, writing in "not observed" when applicable.
2. Add the checks in each column and multiply this sum by the numerical weight (O = 4, S = 3, M = 2, U = 1).
3. Divide the total obtained in step 2 by the number of objectives assessed, (i.e., do not count objectives marked "not observed") to determine score.
4. Convert score to percentage grade based on scale below keeping in mind that all critical indicators (marked by an asterisk) must be met at the satisfactory level for students to receive a passing grade in clinical.
5. Calculate course grade by multiplying theory grade by .6 and clinical grade by .4 and adding the two figures.

GRADING SCALE

PERCENTAGE	POINTS	LETTER GRADE
100	4.00	
99	3.98	
98	3.92	
97	3.86	
96	3.79	
95	3.73	
94	3.66	A
93	3.59	
92	3.52	A-
91	3.46	
90	3.40	B+
89	3.33	
88	3.26	
87	3.20	
86	3.13	B
85	3.07	
84	3.00	B-
83	2.95	
82	2.89	C+
81	2.83	
80	2.78	
79	2.72	C
78	2.66	C-
77 and below	2.65	F

*Critical Indicators Must Receive a Satisfactgory Score.

SCORING DESCRIPTORS

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2. Unable to analyze and synthesize information with guidance.
3. Unable to make appropriate clinical judgements.
4. Does not accept responsibility for own actions.

DIRECTIONS FOR DETERMINING CLINICAL GRADES

1. Mark level of student performance for each objective, writing in "not observed" when applicable.
2. Add the checks in each column and multiply this sum by the numerical weight (0 = 4, S = 3, M = 2, U = 1).
3. Divide the total obtained in step 2 by the number of objectives assessed, (i.e., do not count objectives marked "not observed") to determine score.
4. Convert score to percentage grade based on scale below keeping in mind that all critical indicators (marked by an asterisk) must be met at the satisfactory level for students to receive a passing grade in clinical.

GRADING SCALE

PERCENTAGE	POINTS	LETTER GRADE
100	4.00	
99	3.98	
98	3.92	
97	3.86	
96	3.79	
95	3.73	
94	3.66	A
93	3.59	
92	3.52	A-
91	3.46	
90	3.40	B+
89	3.33	
88	3.26	
87	3.20	
86	3.13	B
[illegible]	3.07	
84	3.00	B-
83	2.95	
82	2.89	C+
81	2.83	
80	2.78	
79	2.72	C
78	2.66	C-
77 and below	2.65	F

*Critical Indicators Must Receive a Satisfactgory Score.

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING PRACTICE I
Preclinical Required Assignments

Completed
Date

ATTENTION STUDENTS: You must complete the following checklist before you attend your first scheduled clinical day at the birth center setting.

________ 1. View AV "Baby Basics".

________ 2. View AV "Newborn Assessment".

________ 3. View AV "Birth Center Hospital Orientation"

ATTENTION STUDENTS: You must complete the following checklist before you attend your first scheduled clinical day at the perioperative setting.

________ 1. View AV "AIDS and Health Care Workers" by Dr. Richard Keeling.

________ 2. View AV/Computer "Eliminating Medication Errors" on computers in Rooms P204 and P108 (Study Center).

Instructions:

	Screen Display	SN Action
1.		Turn computer and printer on.
2.	(Date . . . .)	Hit Return key.
3.	(Time . . . .)	Hit Return key.
4.	(menu list)	Hit letter corresponding to "Eliminating Medication Errors
5.	(1 run courseware)	Hit 1.
6.		Hit return key to advance to next several screens.
7.		Follow directions given on screen and complete the program.

At the end of the program you must print a copy of your grade/score to be given to Judy Speckhart.

Instructions:

	Screen Display	SN Action
1.	Do you wish to record lesson you just completed (Y/N):	Hit Y key.
2.	Do you wish to enter student record information (Y/N):	Hit Y key.
3.	Fill in student information.	(You may omit license number by hitting Return key.)
4.	(Dep/Unit)	Type INTNSG and hit Return key.
5.	(position)	Type ADNS and hit return key.
6.	Is the information listed above correct (Y/N):	Hit Y key.
7.	Do you wish to receive a student certificate (Y/N):	Hit Y key.

8. Turn in bottom half of certificate to Judy Speckhart and remember to turn off computer and printer.

JS/1-90/bh
IN/Preasign.P1

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING PRACTICE I
Support Services

Community Support Services: 5 hours

Weeks 1 & 2: 1 hour lab - instructor directed

Discussion of maternal-child services (AFDC, Medical Assistance, DPI homebound program, WIC, La Leche League).

Week 3: 1 hour lab - student directed

Each student will explore a maternal-child health agency or service in the community and complete the assignment handout. Each student will present the information about the agency to classmates during Lab #3.

Weeks 1 & 2: (clinical experience)

OBJECTIVE: Identify the roles of the nurse in the clinic setting. Emphasis is placed on the roles of investigator, caregiver, and teacher. Refer to the clinical evaluation tool for specific objectives regarding these roles.

Each student will have two hours of a clinical experience. This will be a participatory/observation experience in a maternal-child clinic. Dress in uniform with name pin. Complete assignment sheet and return to instructor the following Monday.

EW/1-90/bh
INP1Supp.W90

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

INTERMEDIATE NURSING
Maternal Child Support Services

Independent Assignment

Identify and explore a community service agency that provides maternal child health services. Complete the following questions to present the information to classmates during a class lab. Provide any handouts/pamphlets to supplement presentation.

Name of Agency:

Address:

Telephone Number:

Contact Person

How is the agency funded?

What services does this agency provide?

How is eligibility for services established?

How are the clients identified or referred for services?

What is the role of the nurse (investigator, caregiver, teacher) in working with families receiving the services? How are the services integrated in the total plan of care?

What is your appraisal of this agency and its services?

EW/1-90/bh
IN/MatChild.SS

EXHIBIT N

CHIPPEWA VALLEY TECHNICAL COLLEGE
Associate Degree Nursing-Technical Program

Course Syllabus

COURSE: 510-123 Pathophysiology II CREDITS: 2

PREREQUISITES: Pathophysiology I

LEAD INSTRUCTOR:

RESOURCES:

Textbooks:	Porth, C. M., Pathophysiology: Concepts of Altered Health States, 2nd ed., Lippincott, 1986.
References:	Metheney, N. M., Fluid and Electrolyte Balance: Nursing Considerations, Lippincott, 1987. Tortora, G. J. and Anagnostakos, N. P., Principles of Anatomy and Physiology, 5th ed., Harper & Row, 1987.

COURSE DESCRIPTIONS:

This course is a continuation of Pathophysiology I. It's purpose is to continue to expand on the student's understanding the factors which support and detract from homeostasis. Specifically the course focuses on endocrine, metabolism, and nutrition processes; neuromuscular function; skeletal function and body movement; and function of the reproductive systems.

COURSE OBJECTIVES:

This course provides learning experiences which will enable the student to:

1. describe patterns of abnormal hormonal control of metabolism and growth in man.
2. describe pathological processes affecting human nutrient ingestion and use.
3. describe common patterns of impairment of neuromusculoskeletal function in man.
4. explain common pathologies of the human reproductive systems.
5. discuss the adaptive processes occurring in the body during the above disturbances in homeostasis.

UNITS OF INSTRUCTION:

1. Alterations in nutrition and metabolic patterns.
2. Alterations in neuromuscular function.
3. Alterations in skeletal support and movement.

4. Alterations in function of the reproductive systems.

METHODS OF INSTRUCTION: Lecture, discussion.

METHODS OF EVALUATION AND GRADING:

Three objective in-class unit examinations will determine the course grade. Students must achieve an average of 75% to pass the course.

POLICIES AND PROCEDURES:

Students are strongly encouraged to attend all class sessions. Attendance will be taken at all class sessions as specified by Chippewa Valley Technical College policy.

Examinations may be missed only due to illness or other serious difficulty. Examination which are missed may be made up within one week of the original test date by completion of an alternate essay test form.

RA/10-89/bh
Patho/P2CSyll.W90

Pathophysiology II
Course Syllabus/Outline

APPROXIMATE SCHEDULE OF LEARNING ACTIVITIES

1. Course introduction
2. Overview of endocrine control of metabolism
3. Impaired control of growth and metabolism.
4. Impaired control of growth and metabolism.
5. Diabetes mellitus
6. Altered gastrointestinal function
7. Altered gastrointestinal function
8. Altered hepatobiliary and pancreatic function
9. Altered hepatobiliary and pancreatic function
10. UNIT EXAM #1
11. Neuromuscular and autonomic nervous system function
12. Neuromuscular and autonomic nervous system function
13. Neuromuscular and autonomic nervous system function
14. Altered motor function
15. Altered motor function
16. Discussion: Altered neuromuscular function
17. Special sensory disorders: vision
18. Special sensory disorders: vision
19. Special sensory disorders: hearing
20. Disordered cerebral function
21. Disordered cerebral function
22. Pain
23. UNIT EXAM #2
24. Skeletal trauma and infection
25. Skeletal trauma and infection
26. Congenital, metabolic, and neoplastic disorders of bone
27. Congenital, metabolic, and neoplastic disorders of bone
28. Congenital, metabolic, and neoplastic disorders of bone
29. Rheumatic disorders
30. Rheumatic disorders
31. Alterations in function of the male reproductive system
32. Alterations in function of the female reproductive system
33. Alterations in function of the female reproductive system
34. STDs
35. UNIT EXAM #3
36. Course evaluation

RA/10-89/bh
Patho/P2CSyll.W90

Pathophysiology II
Course Syllabus/Outline

UNIT I: Alterations in Nutrition and Metabolic Patterns

TOPIC	OBJECTIVES	READING (* = optional)
Endocrine Control of of Metabolism	Explain general mechanisms of hypo- and hyperfunction of the endocrine glands.	P: Ch 37, 38
	Explain the role of insulin, glucagon, catecholamines, somatostatin, growth hormone, and the glucocorticoids in control of metabolism.	
Altered Control of Growth and Metabolism	Describe causes and results of disorders of secretion of growth hormone, thyroid hormone, and adrenal cortical hormones.	P: Ch 39
Diabetes Mellitus	Compare and contrast Type I and Type II diabetes mellitus.	P: Ch 40
	Describe acute complications of diabetes mellitus: -hypoglycemia -diabetic ketoacidosis -hyperosmolar coma.	
	Describe chronic complications of diabetes mellitus.	
Altered Gastrointestinal Function	Define and describe symptoms of gastrointestinal dysfunction.	P: Ch 41* P: Ch 42
	Explain causes and results of inflammatory and neoplastic disorders occurring in the esophagus, stomach, small intestine and large intestine.	
	Describe causes and results of altered gastrointestinal motility.	
	Explain malabsorption syndrome.	

Pathophysiology II
Course Syllabus/Outline

TOPIC	OBJECTIVES	READING (* = optional)
Altered Hepatobiliary and Pancreatic Function	Describe causes and characteristics of hepatitis, cirrhosis, and liver cancer. Explain tests of liver function. Describe biliary tract disorders. Explain causes and results of pancreatic dysfunction.	P: Ch 43

UNIT II: Alterations in Neuromuscular Function

Neuromuscular and Autonomic Nervous System Function	Describe organization and functions of the sympathetic and parasympathetic nervous systems. Explain the use of drugs which affect the ANS. Describe organization of nervous control of skeletal muscle.	P: Ch 44, 45*
Altered Motor Function	Describe disorders of skeletal muscle function occurring within the upper motor neuron, lower motor neuron, extrapyramidal tract, motor end plate, and muscle.	P: Ch 48
Special Sensory Function	Describe causes and results of: -external eye disorders -cataracts -glaucoma -retinal disorders -eye movement disorders. Describe causes and results of external, middle and inner ear disorders. Describe causes and results of vestibular dysfunction.	P: Ch 46

TOPIC	OBJECTIVES	READING (* = optional)
Disordered Cerebral Function	Describe the concept of increased intracranial pressure.	P: Ch 47
	Explain the effects of traumatic head injury on the brain and intracranial pressure.	
	Explain types and characteristics of CNS infections.	
	Explain causes and manifestations of seizure activity.	
	Describe mechanisms and symptoms of altered consciousness.	
	Describe selected organic brain disorders.	
Pain	Explain theories of pain transmission.	P: Ch 49
	Describe common pain syndromes: -headache -neuralgias -phantom limb pain	

UNIT III: Alterations in Skeletal Support and Movements

TOPIC	OBJECTIVES	READING (* = optional)
Skeletal Trauma and Infection	Describe mechanisms and signs and symptoms of soft tissue injury.	P: Ch 50* P: Ch 51
	Describe classifications of fractures.	
	Describe healing of bone tissue.	
	Explain complications of fractures including compartment syndrome, fat emboli, and non-union.	
	Describe etiology and cause of osteomyelitis.	

Pathophysiology II
Course Syllabus/Outline

TOPIC	OBJECTIVES	READING (* = optional)
Congenital, Metabolic, and Neoplastic Disorder of Bone	Describe common skeletal abnormalities and injuries of childhood.	P: Ch 52
	Describe abnormal metabolism and signs and symptoms occurring in osteoporosis, osteomalacia, and Paget's disease.	
	Describe common patterns of neoplasia in skeletal tissues.	
Rheumatic Disorders	Distinguish between rheumatoid arthritis and osteoarthritis in terms of etiology, signs and symptoms, and course of disease.	P: Ch 53
	Describe signs, symptoms and course of inflammatory diseases of the axial skeleton.	
	Describe etiology, manifestations, and course of gout.	

UNIT IV: Alterations in Function of the Reproductive Systems

TOPIC	OBJECTIVES	READING (* = optional)
Alterations in Function of the Male Reproductive System	Describe common disorders of the penis, scrotum, testes, and prostate gland.	P: Ch 32* P: Ch 33
Alterations in Function of the Female Reproductive System	Describe common disorders of menstruation.	P: Ch 34* P: Ch 35
	Describe signs, symptoms, and causes of common inflammatory processes of the female reproductive system.	
	Describe patterns of benign and malignant neoplasia of the female reproductive system.	

TOPIC	OBJECTIVES	READING (* = optional)
Sexually Transmitted Diseases	Describe signs, symptoms, and epidemiology of common sexually transmitted diseases.	P: Ch 36

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EXHIBIT O

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN
ASSOCIATE DEGREE NURSING

DRAFT

COURSE SYLLABUS

COURSE: 510-153 Intermediate Nursing Practice II

CREDITS: 3 credits: 162 hours

PREREQUISITES: All courses listed prior to the session in which this course is taken. 510-123 Pathophysiology II and 510-132 Nursing Skills II are taken concurrently with this course. Track II enrollees also take Advanced Nursing I concurrently with this course.

LEAD INSTRUCTOR: Roz Anderson

RESOURCES:

Textbooks: Textbooks from past and current courses will be used to support clinical learning experiences. The primary textbooks include:

Brunner and Suddarth, Textbook of Medical-Surgical Nursing, 6th Edition, Lippincott, 1988.

Fischbach, A Manual of Laboratory Diagnostic Tests, 3rd Edition, Lippincott, 1988.

Ladewig, London, and Olds, Essentials of Maternal-Newborn Nursing, 2nd Edition, Addison-Wesley, 1990.

McFarland and McFarlane, Nursing Diagnosis and Intervention, C.V. Mosby, 1989.

Shlafer and Marieb, The Nurse, Pharmacology, and Drug Therapy, Addison-Wesley, 1989.

References: Current nursing and other professional journals.

COURSE DESCRIPTION:

In the preceding clinical course an application environment was provided for students to try out systematic thinking patterns. The present course offers an expanded time frame for continued application and practice. In addition, while continuing to use the same familiar environment, it provides opportunity to link knowledge obtained in other concurrent nursing courses to the clinical setting. The desired result is student competence which will consistently broaden and deepen. Competency will be demonstrated by effective therapeutic interaction which allows the student to: increase their depth of data collection, accurately determine and prioritize multiple nursing diagnosis, and, as a result, develop, implement, evaluate and revise holistic, ongoing plans of care. Consequently, actual and potential nursing diagnosis will be addressed, use of the teaching/learning process as a method of nursing intervention will be incorporated, and patient participation in the planning process will be understood as essential for success. Familiarization with the work environment is also expected to deepen.

PERFORMANCE COMPETENCY:

While taking this course the student will demonstrate all of the performance competencies identified in the course syllabus of 510-151 Intermediate Nursing Practice I. Upon successful completion of this course, the student will demonstrate these additional performance competencies.

The student will be able to:

1.00 Articulate how they use systematic thinking patterns in planning and providing care for more than one client.

2.00 Implement care plans that reflect:

- a) involvement of clients in the planning and evaluation process
- b) prioritizing multiple nursing diagnosis
- c) identifiable caring behaviors

3.00 Connect own perception of therapeutic interactions that occur in the clinical setting to descriptors of therapeutic interactions addressed in current seminars and prior courses.

INSTRUCTION:

During the summer session offering of this course each student will be scheduled for 17 hours of clinical practice/week for 8 weeks. Four two-hour seminars are scheduled for orientation to this course and clinical case studies.

During the semester offering of this course each student will be scheduled for 11 hours of clinical practice/week for 14 weeks. Four two-hour seminars are scheduled for orientation and clinical care studies. The clinical setting includes but is not limited to the perioperative setting. Students will have opportunities to observe labor and delivery.

Methods of Instruction

Preconference discussions
Postconference discussions
Individual student conferences
Supervised clinical laboratories
Campus lab discussions
Computer assisted instruction
Audiovisuals

Methods of Evaluation

Evaluation of clinical competency
Written requirements:
 4 nursing care plans
 1 teaching/learning plans
 2 process recordings
 1 observational paper
Labor and delivery setting

GRADING:

The course grade is determined by instructor's evaluation of the student's clinical performance using a point system on evaluation forms which are derived from course objectives. The student must have a passing grade in each clinical rotation in order to pass the course. The lowest acceptable passing grade is a "C" (78%). (See attached Clinical Evaluation Form.)

POLICIES AND PROCEDURES:

The students are expected to prepare prior to coming to clinical. If any student is unprepared to provide SAFE nursing care, the instructor may dismiss the student from clinical and require the student to meet with the program supervisor prior to returning to the clinical setting.

Clinical Attendance:

Clinical attendance is extremely important. Excessive clinical absence will make it impossible to meet the course objectives. If excessive absences occur, the clinical instructor will not be able to validate safe practice in intermediate nursing skills.

Therefore, the student may receive a failing grade for clinical. More than one or two absences are considered excessive for this course. (Remember, there is a good possibility of bad driving conditions, so use good judgment regarding attendance.) Absences are recorded and reported to Student Services where they are recorded on the student's record. Students with excessive absences are referred to a Student Services counselor. Students are expected to formulate a plan to correct the behavior.

Nursing Skills:

The student must have successfully completed each nursing skill in campus lab before the student may perform that skill in the clinical setting.

Reporting Absence:

CLINICAL LABORATORY:

1. Call Nursing unit.
2. Identify yourself, your instructor and leave a message regarding your absence.

CAMPUS LAB/SUPPORT SERVICES:

1. Call (715) 833-6417.
2. Identify yourself and give the information regarding your absence, including the instructor's name(s) in each class for which you will be absent.

CHIPPEWA VALLEY TECHNICAL COLLEGE
EAU CLAIRE, WISCONSIN

CLINICAL

COURSE: INTERMEDIATE NURSING PRACTICE II

le Points	O (4)	S (3)	M (2)	U (1)	Supportive Statements
Caregiver					
1.00 Demonstrates caring behaviors, critical thinking and utilization of the nursing process in providing nursing care to individuals and their families					
1.01 Assessment					
*A. Completes holistic data base using Gordon's Patterns					
B. Analyzes the data using standards					
1.02 Nursing Diagnosis					
A. Writes nursing diagnoses using PES^ format					
B. Prepares list of actual and potential nursing diagnoses that are validated by the data base					
1.03 Priority Setting					
A. Prioritizes nursing diagnoses using a standard, eg. Maslow's Hierarchy of Needs					
1.04 Plan					
A. Develops individualized care plans for assigned clients					
B. Writes measurable outcome criteria that are relevant to the nursing care plans					
C. Selects nursing interventions that are based on scientific rationale and derived from etiology of the nursing diagnosis					
D. Documents resources used to support the scientific rationale for interventions					
1.05 Interventions - Dependent					
A. Applies knowledge of medications in caring for clients					
*B Implements treatments safely and effectively					
1.06 Interventions - Independent					
A. Establishes helping-trust relationships with assigned clients and their families					
B. Initiates caring behaviors with assigned clients and their families					
*C. Safely intervenes to promote, maintain and restore client's health status					
D. Documents interventions using designated format i.e., DAR, SOAP, narratives					
1.07 Evaluation					
A. Collects data specific to the established outcome criteria					
B. Compares data to outcome criteria					
C. Judges whether outcome criteria were met, not met or partially met					
D. Revises nursing care plan based on evaluation results					
Subtotal					

ritical Indicators
^Problem Etiology Symptomatology

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IN/ClinEval.IP2

EVALUATION

☐ INSTRUCTOR ☐ STUDENT

DATE: ____________________

Scale Points	O (4)	S (3)	M (2)	U (1)	Supportive Statements
Teacher 2.00 Utilizes the teaching-learning process when providing care to assigned clients					
2.01 Assesses the client and family for learning needs					
2.02 Identifies barriers to learning					
2.03 Assesses learner readiness					
2.04 Develops a teaching plan to meet the learning needs of a client and family					
2.05 Implements a teaching plan					
2.06 Evaluates effectiveness of teaching plan					
Subtotal					
Manager 3.00 Identifies and utilizes human resources for the provision of nursing care					
3.01 Organizes time to provide care efficiently					
3.02 Schedules nursing care to reflect priority of client health care needs					
3.03 Uses proper channels of communication to maintain flow of information and ideas.					
Subtotal					
Member of Discipline 4.00 Assumes responsibility for participation as a member of the health care team					
*4.01 Applies ethical and legal standards, ie. A. Uses ANA Nursing Standards of Practice B. Complies with Code of Ethics C. Maintains Confidentiality D. Legally documents client care					
4.02 Complies with school and agency policies, ie., dress code, punctuality, follows channels of communication					
4.03 Demonstrates personal and professional accountability A. Assesses own strengths and limitations B. Assumes responsibility for own actions C. Assumes responsibility for learning					
*4.04 Protects health of self and members of health team while implementing client care, i.e., universal secretion precautions					
4.05 Critically evaluates own experiences in initiating specific caring behaviors with clients					
Subtotal					
Investigator 5.00 Uses rational thinking strategies to obtain information relevant to client care					
5.01 Exhibits intellectual curiosity					
5.02 Demostrates characteristics of fairmindedness					
5.03 Actively seeks imaginative solutions to problems					
5.04 Identifies written resources relevant to client care					
Subtotal					
TOTAL SCORE					

____________________ Instructor's Signature

____________________ Student's Signature

SCORING DESCRIPTORS

OUTSTANDING: Consistently superior in clinical performance, skill, synthesis of learning and application of nursing principles. Functions above expectations of student at this level.

1. Consistently functions safely and effectively with minimal guidance.
2. Demonstrates superior ability to analyze and synthesize information.
3. Demonstrates sound clinical judgement.
4. Seeks out and assumes responsibility beyond that required.

SATISFACTORY: Safe clinical performance demonstrates expected skills, synthesis of learning and application of nursing principles at expected level.

1. Consistently functions safely and effectively with occasional guidance.
2. Demonstrates ability to analyze and synthesize information with occasional guidance.
3. Makes appropriate clinical judgements with guidance.
4. Recognizes own limitations and seeks appropriate assistance.

MINIMAL: Clinical performance: is safe, background knowledge is deficient. Inconsistent safe clinical performance; demonstrates expected skills, synthesis of learning, and application of nursing principles at expected level with direct supervision.

1. Functions safely and effectively with frequent supervision.
2. Analyzes and synthesizes information with much guidance.
3. Accepts own limitations with guidance and uses resources as directed.
4. Accepts clinical judgements of staff and instructor.

UNSATISFACTORY: Clinical performance inadequate; indicates lack of skill, unsafe nursing practice, inadequate depth of knowledge, or application of nursing principles. Functions below expectations of student at this level.

1. Unable to function safely and effectively without constant supervision.
2. Unable to analyze and synthesize information with guidance.
3. Unable to make appropriate clinical judgements.
4. Does not accept responsibility for own actions.

DIRECTIONS FOR DETERMINING CLINICAL GRADES

1. Mark level of student performance for each objective, writing in "not observed" when applicable.

[illegible] Add the checks in each column and multiply this sum by the numerical weight (O = 4, S = 3, M = 2, U = 1).

3. Divide the total obtained in step 2 by the number of objectives assessed, (i.e., do not count objectives marked "not observed") to determine score.
4. Convert score to percentage grade based on scale below keeping in mind that all critical indicators (marked by an asterisk) must be met at the satisfactory level for students to receive a passing grade in clinical.

GRADING SCALE

PERCENTAGE	POINTS	LETTER GRADE
100	4.00	
99	3.98	
98	3.92	
97	3.86	
96	3.79	
95	3.73	
94	3.66	A
93	3.59	
92	3.52	A-
91	3.46	
90	3.40	B+
89	3.33	
88	3.26	
[illegible]7	3.20	
86	3.13	B
85	3.07	
84	3.00	B-
83	2.95	
82	2.89	C+
81	2.83	
80	2.78	
79	2.72	C
78	2.66	C-
77 and below	2.65	F

*Critical Indicators Must Receive a Satisfactgory Score.